The Obstetric Gazette.

Vol. VI. — AUGUST, 1883. — No. 8.

Original Articles.

A CONTRIBUTION TO THE MANAGEMENT OF FACE PRESENTATIONS.

BEING AN INQUIRY RESPECTING THE ADVISABILITY OF UNIFORMLY CHANGING PRESENTATIONS OF THE FACE TO THOSE OF THE VERTEX.

A Paper read before the Society of Ex-Internes of the Cincinnati Hospital, By J. Trush, M.D., Cincinnati, Ohio.

Considering that recent obstetrical writers are all but unanimous in recognizing face presentations as normal or physiological, and accordingly, prescribing an expectant plan of treatment, it may seem presumptuous in one not wielding the pen of authority, to question the excellence of such treatment and suggest modifications; the high rate of mortality however, in these labors, with current management, has seemed to the writer adequate excuse for the proposed inquiry and he trusts his hearers may share this conviction.

The inquiry contemplates: first, a brief review of the present management of face presentations and the eventualities manifesting themselves in this connection; secondly, a consideration of the leading features of the so-called aggressive method of dealing with face presentations, together with the citation of cases, tending to illustrate this plan of treatment, and, thirdly, a few comments on the relative advantages of the two modes of management.

Since the demonstration, by Nägle, of a natural mechanism of labor, in face presentations, obstetric authorities, as well known, have very generally concurred in directing that these presentations should not be interfered with in any other manner, than simply to assist when necessary, in the evolution of the normal movements of the face—head—in its passage through the pelvic canal, *i.e.*, to promote extension if defective, by pressure upon the forehead, during pains; to prevent abnormal, and conduce to normal rotation, by digital traction, etc., in the proper direction, upon the chin; engagement of this part under the pubic arch, being a recognized necessity in face-labors. The assistance, after full anterior rotation of the chin, being the same as in vertex cases, excepting the observance of some extra care in supporting the perineum. The

management, in short, as already intimated, is purely expectant and certainly in keeping with the classification of this presentation as one having a "normal mechanism." The fact, however, is undeniable that this mechanism frequently is not normal; extension may remain defective in spite of every authorized effort to facilitate this motion; engagement then either cannot take place at all, or only after protracted uterine efforts; later, the chin may obstinately refuse to rotate, remaining fixed for hours in the original position, or if rotation do occur, it is in an abnormal direction, the chin gliding into the hollow of the sacrum. Finally, the relative diameters of the maternal pelvis and the fœtal head may be such, that passage of the latter is possible only, after very extensive molding, the result of protracted and vigorous labor. In any of these several events, the assistance of the accoucheur will be required; either he delivers with forceps, or turns upon the feet, or performs craniotomy. But forceps extraction of face presentations from the superior strait, or of a non-rotated face from the excavation, is no easy task, and anything, but a harmless operation; neither is turning upon the feet, when practiced as a dernier resort; not to speak of the destructive operation alluded to above.

This being the probable course and these the events of labor in face presentation, how do such labors affect the well-being of the parties most concerned, the mother and her child? On this point Winkel(1) informs us, that *six* mothers and *thirteen* children, per 100 face-labors are lost; Playfair(2) estimates the mortality of children born in face-presentation with *normal* rotation at ten per cent.; and, if the rotation be *abnormal*, death of the child is *almost certain*. No maternal death-rate is given, but the very suggestive remark appears that, as the labor is apt to be prolonged, she, the mother, "is more exposed to the risks attending tedious labors." Churchill's (3) figures from various authors, exhibit a similar average of deaths in these cases, both of mothers and of children. In comparison, note the mortality in vertex labors, as given by Pinard: (4) only *two* per cent, of children and *one-third of one per cent.* of mothers succumb from the effects of this class of labors. In other words, one mother only out of every 300, loses her life in parturition with vertex presentation, while with that of the face, *eighteen* mothers out of every 300 suffer death; and, among children, of those born in face presentation, *thirty-nine* per 300 die, while only *six* of an equal number born in vertex presentation share this fate.

With these data, in relation to the prevailing management of face presentations, as a basis of departure, we may proceed to examine the main peculiarities of the "aggressive" plan of treating face presentations. The mode, as indicated at the head of this paper, consists in nothing more nor less, than CONVERSION of the "*face*" to a *vertex*-presentation, at the very outset, or as early as possible in the progress of the labor; the

change to be effected by one of two different methods of procedure: one, the older, known as that of Hodge, or the *internal* method; the other, that of Schatz, or the *external* method—a reversion, it will be perceived, to ancient doctrines, but with modernized methods of procedure. To the late Prof. Hodge, if I mistake not, is due the honor of having developed and promulgated the first *definite* plan of internal manipulations for the purpose in question and of having pointed out the precise conditions, under which the operation might be most safely carried into effect. "Immediately after the os uteri is adequately dilated," says Hodge, (5) and before the presenting part has passed this opening, recourse should be had to version by the vertex, for, under these circumstances, he proceeds, "the operation, especially in multiparous women, can be easily and rapidly performed, without much suffering to the mother, and will effectually deliver both the child and its parent, from all the unpleasant incidents, delays and dangers of facial presentations," and further on, "if, however, the practitioner be not present, until the face has passed the circle of the os, it would be wrong to resort to the version." The procedure is simple: the operator passes his hand in the usual manner through vulva and vagina, up to the uterine orifice, enters the cavity of this organ and ascends above the brim, in relation with the forehead of the fœtus, thence pushing the hand onward over bregma and vertex, until the occipital protuberance is reached, which it firmly grasps; maintaining this hold, the hand is now slowly withdrawn into the excavation, and the object of the operation, flexion of the head, is accomplished; not however, until engagement of the new presentation has fairly taken place, will it be safe for the operator to relinquish his hold upon the vertex, lest renewed extension occur.

We have seen that according to Hodge this operation should not be attempted after the face has passed the circle of the os; doubtless it is much easier of execution in the presence of the conditions prescribed, but by no means impossible under *less* favorable surroundings. Thus the late Dr. John Parry (6) turned upon the vertex—under chloroform—after the head had been for hours lodged upon the inferior strait and after repeated efforts, both by himself and by the attending physician to deliver with forceps, had failed and craniotomy seemed the only resource. Unwilling to perforate the head of a living child, Dr. Parry determined to try version upon the vertex; had the patient thoroughly anæsthetized and now succeeded, "without much difficulty," he states, in dislodging the head from the excavation and then flexing it; under renewed application of the forceps, the delivery was now speedily accomplished and both mother and child saved. Another instance of version upon the vertex in face presentation with retracted os, was reported some years since by Dr. Tate of this city. The patient had been in labor for many hours, the os uteri, as mentioned fully dilated and retracted, but still no

descent; finding the head movable, version upon the vertex, by the Hodge method, was decided upon and the change effected without special difficulties—a rapid delivery being the result of the version and no untoward symptoms following. Finally, the writer himself, a few months ago, encountered a case of face presentation, in which version upon the vertex, by this method, was practiced, under nearly the conditions prescribed by Hodge. The particulars are these: Called at 2 o'clock, a.m., to Mrs. M., in labor with third child; had been in "pains" since 7 o'clock the previous evening; os largely dilated, membranes intact, face presenting. The announcement of the presentation, in answer to the usual query, "if all was right," creating visible alarm in the patient as well as her husband, the cause of these fears was demanded and the information obtained that the last child had been *born* in this manner, and that the labor had been very severe and protracted; patient felt confident "she should never live through another such a siege." The membranes giving way during this recital, I was led to hope that engagement and descent might now take place; an hour was therefore spent in waiting, the pains in the mean time being frequent and vigorous, but all to no purpose; the face remained where I had found it, at the inlet; still readily movable between pains. With the previous history, and the present condition of the case before me, I deemed the change of presentation not only justified, but urgently indicated and accordingly proceeded, as remarked, by the internal method, to bring down the vertex and accomplishing this task so readily that the whole procedure did not occupy beyond five minutes and giving apparently but little pain. Half an hour later the child was born, crying vigorously and the mother greatly rejoiced at her speedy delivery. Lying-in period absolutely devoid of anomalies.

These cases show that the *internal method* of version upon the vertex is not only a feasible, but at the same time, a very efficient procedure; having been successfully executed, as shown, under difficulties believed to be insurmountable and with results, the most salutary that could be desired. Still, obstetricians, though recognizing the desirabilty of the conversion of face to vertex, were loth to employ this method; the internal manipulations were objectionable. To avoid these objectionable features and at the same time, secure the full benefits of the change in question, Prof Schatz (1) of Rostock, devised an *external* method of flexing the extended head. This procedure presupposes proficiency in external, obstetric examination,—the operator must be able to diagnosticate with certainty, by this means, the presentation in question. Then certain conditions are requisite, viz., the abdominal and uterine walls must be flaccid; not too thick, nor unduly sensitive. The respective manipulations in the authors words, are as follows: "In the interval between the pains, the operator seizes the shoulder and breast of the child with one

hand, and pushes both upwards and to the side where the back lies; as soon as the breast and shoulder have been brought into the long axis of the fœtus the pressure is directed, no longer upwards, but toward the back of the child, at the same time the other hand firmly grasps the fundus uteri with the breech and pushes it toward the side to which the thorax points, but care must be taken not to antagonize the first hand, but rather press perpendicularly towards it; then the pressure of the second hand should be directed laterally and downwards, or directly downwards, in order to remove the shoulder and thorax as far as possible from the long fœtal axis to the side where the back lies. In case the brow should again seek to slip upwards, the hand of an assistant must prevent this evasion by suitable pressure. Schatz thus succeeded in effecting the version in question in *one* case; Fritsch, by the same method, accomplished it in a *second*, and Welponer, of Vienna, in a *third* case(8); and Speigelberg(9) was so favorably impressed by this procedure that he speaks of it as "the only reliable method for rectifying a face presentation." But even if not so reliable as represented by this author, it has the one great advantage, *of doing no harm.*

There being no questioning the great superiority of *vertex* over *face* presentations, an estimate of the relative advantages of the opposing plans of treatment of facial presentations, the "*expectant*" and the "*aggressive*," need only take into consideration the objections which have been urged against the latter plan of dealing with these presentations; for if version upon the vertex could be effected in a harmless manner, at the outset of labor, the "aggressive" plan would deserve undoubted preference. Against the *external* method, as already intimated, the only objection which can be raised is *inefficiency;* operators perhaps failing as often as they succeed; the requisite conditions may be wanting even in multiparous women, while in the primiparæ this will form the rule, and that too in spite of anæsthetics which, through highly useful, can only partially correct the unfavorable status; or, the needful familiarity with external obstetric manipulations may not be at command and the endeavor fail for this reason in otherwise favorable cases. But all this must not proscribe the effort; on the contrary, being harmless and its object most desirable, it should never be omitted in cases of facial presentation.

The internal mode, unfortunately, is not so free from objections as its congener the external. "Inefficiency" also is cited as one of the objectionable features, but the principal charge against the process has always been its alleged liability to attendant injurious effects. It is claimed in this connection that there is danger of laceration; danger of septic infection, and that the manipulations are decidedly painful. The latter objection certainly is but partially true; the really painful part of the

operation consists in the penetration of the ostium vaginæ; now this orifice in the majority of pleuriparæ is sufficiently large to admit the hand of the accoucheur without undue or painful tension. The pain subsequent to this step arises mainly from uterine action, elicited, it is true, to some extent, by the operating hand. We have the statement of Hodge, already cited, that in the multipara this procedure is not painful; in my own case it certainly elicited no particular manifestations of pain. In the primipara, for obvious reasons, the pain of the operation is apt to be more acute and may necessitate the employment of anæsthetics. A certain degree of danger to septic infection must be admitted; it is, however, slight, if careful disinfection be practiced, and certainly far less than in protracted face labors; the uterine walls, it is to be remembered, are, at the time of the operation, still protected by the membranes; if hence infection occur, it will take place lower down in the genital canal, that part which is exposed to this danger, more or less, in every labor. The liability to lacerations likewise, it seems to the writer, has been greatly magnified. Excepting perhaps at the vaginal and uterine orifices, there is really no good reason why lacerations should occur; the operation is performed early in the labor, as soon as the os uteri is sufficiently dilated to *safely* admit the hand, at a period, therefore, when, ordinarily, the uterine walls are flaccid between pains and yield readily under moderate pressure; it is otherwise in neglected cases, those in which the uterus has firmly settled down upon the fœtus and where consequently entrance of the hand requires the employment of very considerable force; here, rupture unquestionably is to be feared; but then, these are unpromising cases under any procedure and the danger from laceration is doubtless still greater, if the face presentation is permitted to remain.

The charge of "inefficiency," the writer believes, has been already adequately refuted, both by the testimony of Hodge and by the cases herewith cited. In short, insuperable obstacles must be quite exceptional. Wherein should they consist? Certainly the passage of the hand through the vagina is sufficiently easy; neither can there be any particular difficulty in entering the uterine cavity, if the effort be made at the proper time; and, having once a secure hold upon the occiput, can there be any special hindrance to the bringing down of the vertex? The space in the false pelvis is ample, the leverage good, and the opposing surfaces smooth and slippery: surely it ought to succeed.

Obviously then, the charges against the Hodge method, of "*inefficiency* and *pernicious, concomitant effects*," are by no means fairly sustained; and, in any event, such effects must be quite insignificant, as compared with the injuries inflicted by a protracted face labor, independent of any operative interference.

The argument advanced being correct, it follows as a logical conclusion

that, in view of the far greater mortality in *face* than in *vertex* labors, the presentations of the face ought not to be permitted to remain, but should be reduced at the outset of the labor to those of the vertex, provided the respective change can be effected without injurious consequences to either mother or child. Further, that the accoucheur has at his disposal certain operative procedures, the "*external*" and the "*internal*" methods of version upon the vertex, by the employment of which, this object can be accomplished in the *manner* and with the *safety* indicated; and further that, as the *external* method is perfectly harmless and besides can be executed before dilatation has occurred, *before*, consequently, the *internal* method can have place, the version should *first* be attempted by this, the *external* mode. That, however, in the event of failure by this process or where the conditions for this mode of operating are manifestly unfavorable, the accoucheur should have recourse to the *internal* method of version by the vertex, under observation, as much as possible, of the rules laid down by Hodge in reference to this point: but, that the attempt should not be abandoned even with less favorable surroundings, provided only that the head be movable at the superior strait.

A management of facial presentations upon this, the "aggressive" plan, would, the writer is persuaded, result in a very decided reduction of mortality and of suffering from this cause.

LITERATURE.

1. Winkel; "*Pathologie der Geburt,*" 1869, from Mundé. "*The Diagnosis and Treatment of Obstetric Cases by External Palpation,*" p. 89, *et. seq.*

2. Playfair, "*Science and Practice of Midwifery*", 3d Am. Ed., p. 316.

3. Churchill, "*System of Midwifery,*" New Am.. Ed. from 4th Eng. Ed., p. 406, et seq.

4. From Mundé—*loc cit.*

5. Hodge, "*Science and Art of Obstetrics,*" p. 335, *et. seq.*

6. "*Am. Journal of Obstetrics,*" May 1875.—also Leishman, "*System of Midwifery,*" 3d Am. Ed., p. 311.

7. "*Archiv für Gynæcologie,*" 5, 1873, from Mundé, *loc cit.*, p. 90, *et. seq.*

8. From Mundé, *loc cit*, 9, Spiegelberg, "*Geburtshülfe,*" 1te Auflage, p. 166.

TRI-STATE MEDICAL SOCIETY.—The ninth annual meeting of the Tri-State Medical Association will be held in Indianapolis, Sept. 18th, 19th 20th. The work is already far advanced and the title of each paper should be sent in sent at once. Papers must not exceed 25 minutes.

It is also the rule that each physician who registers must be a member of a local or state society in good repute. All such are invited.

Notice of papers or cases to be presented may be sent to the chairman of the committee on programme, Dr. J. L. Thompson, Indianapolis, to the secretary, Dr. G. W. Burton, Mitchell, Ind., or to the president, Dr. Wm. Porter, St. Louis.

"EXTIRPATION OF THE UTERUS" AND SOME OTHER THINGS.

By R. S. SUTTON, A.M., M.D., of Pittsburgh, Pa.
Fellow of the American Gynecological Society; of the American Academy of Medicine, and member of the British Medical Association.

Under the first section of the heading of this paper, in the June number of the OBSTETRIC GAZETTE, appears in a paper by O. E. Herrick, M.D., of Grand Rapids, Michigan. This paper is a criticism of foreign surgery, in the department of gynecology, at the same time so unjust and mistaken in its assertions that I cannot refrain from replying to it. Between September, 1881, and February 10th, 1883, I stood by the operating table of more than a dozen of the leading gynecological surgeons of Great Britain and the Continent of Europe. Among these surgeons I count my friends Mr. Lawson Tait, and Dr. A. Martin, of Berlin, toward whom Dr. Herrick directs his criticisms most particularly. The case which Dr. Herrick so violently denounces, viz: extirpation of the uterus for prolapsus, was performed by Dr. Martin on the 27th day of January, 1882, and I stood at his right elbow and witnessed it and have the notes of the case before me at this moment. The patient was a middle-aged woman. Her uterus was lying between her legs, complete procedentia uteri, the cervix was entirely covered with a deep ulcer secreting pus enormously. This ulcer was as large as a silver dollar. On the anterior vaginal wall were two abraded, granulating, pus secreting surfaces. The vaginal walls were thick and heavy. Professor Schroeder had twice operated on this woman for the cure of this condition and both operations had failed. Dr. Martin had repeated Professor Schroeder's attempts and failed.

He could now do but one of two things, viz: close up the vagina against a menstruating uterus, or remove the uterus. He did the latter, the woman made a good recovery, has left a good vagina, and not one a cul de sac for foul discharges and a source of constant suffering. Martin removed this uterus with *the loss of less than two tablespoonfuls of blood*, less than I generally lose for a lacerated cervix operation. While I could not always agree with Dr. Martin in some of his minor operations, I never saw him or Professor Schroeder remove a uterus in a case in which I thought the operation unjustifiable and I saw them remove a good many. Because the ancients did this operation is no reason that it should not be revived, and it is no proof that because the ancients did it that Schroeder and Martin can't do it better. Their patients rarely die of the operation, which as they do, it is scarcely to be called a bloody operation. Again, it should be remembered that an extirpation of the uterus is as easy to Martin or Schroeder as amputation of a finger is to most men. Both of them together, I have no doubt, do more gynecological operations every three months than are done in the entire State of Michigan in a year. I have seen Martin do seven operations on seven pa-

tients in two hours, and I have seen Prof. Schroeder do three ovariotomies on the same table in ninety minutes. Is it probable that men like these with no end of cases should regard them merely as so much "material for scientific research?" Is it likely that these men of eminent surgical skill would fail where success was possible? Let me say one thing, I know of no American gynecological surgeon who as an operator is Schroeder's equal, except Dr. Marion Sims.

If Dr. Herrick will visit these men for a few months, as I did, he will do what I did, viz: *he will learn something.*

I quote from Dr. Herrick's article the following wild and incorrect statement:

"Take for instance oöphorectomy, first performed by Dr. Battey, and an operation made comparatively seldom in this country considering the fact that it is an (1) American operation; out of the large number of gynecologists here, not one half of them have ever made the operation, and the few who have, have only made it from one to a dozen times each, showing that the cases must have been carefully selected and the operators extremely cautious about making it except for well-defined indications. Not so with foreign gynecologists, they have taken up the new operation and performed it by the hundreds, if not thousands, of times in both their public and private hospitals and cliniques." Now let us see, in eighteen months' experience in Europe I did not see Battey's operation done once, *and I was with Lawson Tait day after day for nearly three months.* Where does *Dr. Herrick get his data for this statement?*

The operation of our countryman, Dr. Battey, is simply not done at all in Europe and has been entirely supplanted by the operation of Professor Hegar, of Frieberg, Germany, and of Mr. Lawson Tait, of Birmingham, England, *and not lately.* If, for any of the conditions of which Dr. Battey's operation was intended to meet, an operation is required, the Hegar-Tait operation is done and not Battey's operation.

Moreover, Battey's operation was for the removal of sound ovaries, and the ovaries only. Prof. Hegar and Mr. Tait remove both ovaries and tubes very often, *but only when they are diseased, unless* for the cure of *epilepsy* or to arrest the *growth of fibroid tumors.* I saw but one patient abroad upon whom Battey's operation had been done, it was for the cure of epilepsy. Lawson Tait showed me the case. He said, I never do Battey's operation now. I did not see the ovaries removed as Battey devised once in Europe. Mr. Tait removes lots of ovaries and tubes for the arrest of fibroid growth, but when there is no fibroid tumor he takes out *only diseased ovaries.* If Dr. Herrick has any doubts on this point, if he will come to me in Pittsburgh I will show him some of them and I have no doubt he will get as great a revelation in regard to Mr. Lawson

1. An old operation revived. Done by the Lydian Kings and also by a Hungarian sow gelder [Sutton].

Tait and the European spayers as did one of my Chicago colleagues when he examined them. Now I hope Dr. Herrick will alter his views in regard to our foreign colleagues and I will gladly answer any questions he may propound, if I can—I was long abroad and had access to every thing, and I don't speak as did a certain Michigan professor of surgery when he began his report of a number of ovaritomies by saying "since my visit to Dr. Keith." When I began to read the report I supposed he had seen Keith operate, but when I asked my friend, Dr. Keith, how long he visited him, he replied he did not see me operate, but spent an hour or two talking to me in the room here. Now I want to ask Dr. Herrick if it might not be as good for science to correct these shams in Michigan professors as to find so much fault with foreign surgeons, especially kind to Americans.

POP-CORN.—FOR THE VOMITING OF PREGNANCY.

By H. v. Sweringen, A M., M.D.

Six or eight months ago or more, I noticed in one of my journals, I cannot now remember which one and I have not the time at present to look it up, a short article by some physician whose name I also fail to recall, recommending ordinary pop-corn as an efficient remedy in the vomiting of pregnancy. If I had not seen it under the circumstances I will presently relate, I would undoubtedly have given it but a passing notice, inasmuch as it did not strike me favorably at first sight.

If its worthy advocate had fixed it up in some kind of "scientific" shape or infused into it a little Latin, as for instance, "Cornum Explosivum" or "Cornum Poppum" or "Poppum Cornum," it might have attracted my attention under *any* circumstances, but bare "pop-corn," simple, harmless, innocent "*pop-corn*" as a high-toned therapeutical remedy among high-toned, scientific physicians was too much, "too utterly too too" for a physician of my cloth and attainments.

But seriously, it proved to be a God-send to me and my patient (more particularly the latter), having had at the very moment one of the most intractable cases probably that ever occurred. I had exhausted the usual remedies employed in this distressing ailment and was about to cauterize or do something to the os uteri when my eyes accidentally fell upon the above named remedy. To make a long story short, it acted *marvelously*, not only in the case referred to, but in three subsequent cases; in fact, in *every* case in which I have prescribed it.

Inhalations of Steam.—Containing oil of eucalyptus, generated from the leaves, are highly recommended in diphtheria by a writer in the English *Lancet*. Thirty-seven cases of recovery are reported.

Society Reports.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting, June 14th, 1883.

The President, Dr. J. Trush, in the chair.

Dr. Julia W. Carpenter reported as follows

A Case of Face Presentation.

According to my custom I saw the patient two weeks before the expected time for completion of gestation, to determine by external examination the presenting part and its position. It proved to be head presentation, in occipito-iliac right-anterior position with vertex well into the pelvic cavity.

I stated to the patient it was in the most natural position without much probability of a change. Two weeks later I again saw the patient. She had increased greatly in size, and although the head was still presenting, it was much higher up than before. The side of the hand could be pressed in between it and the symphysis pubis. I supposed the great increase in amniotic fluid had wrought the change, and wondered what position of head would be the result.

When summoned at 3 o'clock the next morning the external examination showed no change. The internal, showed the os dilated about two inches and very soft and dilatable.

The membrane not being at all tense, I discovered at once the face presentation. It was the left mento-iliac; the least frequent of the two. According to Mme. La Chapelle the left mento-iliac occurring 31 times to 41 of the right. As the head was not yet fixed in the pelvis, I tried to rectify the position by internal manipulation, some external combined with it. The head would rotate, but would not yield to any pressure in the direction of flexion.

I then waited for further dilatation preferring the risks of face presentation to rupture of membranes at that stage, with the uncertainty of change in position. At 7 o'clock a.m. dilatation was complete, and as the head was still not firmly fixed I again tried to flex it, but it was unyielding in that direction.

The descent was slow, but perceptible with each contraction. The amount of water discharged was enormous. The child was born with the cord around the neck four hours after complete dilatation. The rather cast iron rule at Vienna is to use instruments if the birth does not take place three hours after complete dilatation. In this case the mother's strength seemed equal to the occasion, the contractions were regular and

caused steady progress, and the pulsations of the heart were strong. The case ended favorably with the birth of a girl weighing ten pounds.

As the mother's first child was small and labor short, she feared from the greater severity and length of this case that something was wrong and was concealed from her. I told her it was a head presentation, but a difficult position. To the father I explained fully, and took the precaution to state that when the child presented, the face would be very swollen and discolored, the result of the position, but that this appearance would speedily pass away. He afterwards said if I had not prepared him for this he would have been greatly shocked on seeing the child.

This case is not one of special interest, but as they occur only once in two hundred and fifty or three hundred times according to Cazeaux, it is useful to confirm several points.

First, that face presentations are usually primitive and not due to ill directed contraction after the beginning of labor. In this case the head was fully extended from the first, the forehead being entirely on the right side. It was owing to the membrane being not at all tense that I was able to diagnose the face at once.

Second, that face presentations are usually, or very often, associated with an excess of amniotic fluid.

DISCUSSION.

Dr. Palmer spoke of the face presentations as being modified presentations of the occiput, which change might occur just before labor from movements of the fœtus favored by an excess of liquor amnii. Anything that would hinder the descent of the occiput might lead to descent of the chin, and produce face presentations. With pelvic deformity, thus, relatively, they are more frequent.

This ordinary method of delivery in a face presentation with anterior rotation of the chin under the pubic arch, illustrated in a most beautiful manner the wonderful adaptation of the interior of the pelvis to carry any object projected against it, downwards, forwards and outwards. This forward rotation occurs in the vast majority of cases, even when the chin itself originally projected backwardly, provided it is not so far backwards as to impinge upon the posterior inclined pelvic plan. Possibly, even then, anterior rotation may be effected. It is extremely interesting to watch this gradual rotation during the movements of descent.

Rarely, it is produced when the presenting part presses firmly upon the pelvic floor and the perineum is distended. It is there accomplished at once and altogether, as the face is about to be forced through the vulva.

The speaker said he had in consultation encountered one case of mento-posterior position with posterior rotation, in a German woman,

with slight pelvic deformity. The head was impacted in the pelvic cavity, and the child was dead. He endeavored to secure anterior rotation by seizing the head with the fingers and thumb, also by the vectis, and finally by the forceps, but all to no avail. He was obliged to perforate the brow of the fœtus, with Hodge's scissors, and evacuate the cranium, when by means of Braun's cranicoclast, he succeeded in effecting delivery. The woman made a good recovery.

Dr. Trush remarked that he could not agree with the essayist respecting the etiology of face presentations; he was ready to admit that a certain proportion, but not the majority, of cases of face presentation existed prior to the occurrence of labor, that by far the larger number arose from a faulty mechanism of labor, induced by certain anomalies of conformation either on the part of the maternal pelvis, or the fœtal head, or both. Thus, it were well known that the so-called "flat" pelvis predisposed to the development of this presentation in the early periods of the labor. The conjugata vera in these cases being too short to admit the biparietal diameter of the fœtal head the latter would glide off in the direction of the occiput and engagement in the bitemporal take place; if now the occiput should impinge upon the corresponding linia-ilia a face presentation was almost inevitable. The same, with great lateral obliquity of the uterus, provided the abdominal surface of the child was downward. A large, protrading occiput had a similar tendency. Essayist's case certainly could not be adduced in evidence of the ante-labor existence of the face presentation in as much as upon arrival at the bedside of the patient a dilatation of the os to two inches was already noted, labor must therefore have been in progress for sometime, sufficiently pronounced to effect the change in question in the attitude of the fœtal head.

Touching the management of facial presentations in general and this case in particular he fully endorsed the procedure adopted by the essayist, that of attempting to convert the face to a vertex-presentation. The only criticism he had to make was that the attempt had not been sufficiently determined. Certainly the failure could not, in the speaker's opinion, be construed as demonstrating the impracticability of the operation of conversion, seeing that neither of the two principal methods hitherto recommended, had been brought into requisition.

On the score of the "prognosis" of face presentations, however, he must totally dissent from the view expressed by the essayist and by the previou speakers, viz; that face-labors were well nigh as favorable for both, mother and child as those of the vertex; on the contrary, reliable statistics had shown a mortality in these labors, with both parties concerned, of more than double that of vertex labors.

Dr. Palmer replied: Face presentations are not attended with any special mortality to the mother. Labor, as a rule, is longer, and more

painful, but nevertheless, to the mother there is but a slight increase of the risk concerned in normal parturition. And even to the child, the mortality is slight, considerably less than in breech cases. The fœtus does not present a very inviting appearance, but this swelling, discoloration and distortion of its features, greatly improve in an hour, and in a few days usually it assumes the natural appearance.

Dr. Cleveland remarked that he had had little opportunity of observing these cases. Only two cases had occurred in his direct practice. He believed that most of these if left alone would terminate with safety to the mother without assistance, but of course their tedious character jeopardizes the life of the the child. He thought that nearly all of these cases if recognized soon enough, might be converted into occipital positions. If seen before the superior strait had been engaged, by introducing the hand and grasping the occiput and bringing it down and convert it into an occipital position. This was his mode of treatment in one of the cases he has had. He had no doubt that in some cases the head can be shoved out of the pelvic cavity and the occiput brought down.

He thought that possibly the case reported by the essayist might have been managed in this way.

Dr. Gustav Zinke asked the essayist in what her efforts towards rectifying the position of the head consisted. [Dr. Carpenter replied, by making pressure in the direction of flexion.] If he understood the essayist correctly, the os was dilated two inches, the head loosely above the pelvic brim, membranes still intact with large amount of liquor amnii. Considering all this, it seems to have been a very favorable case for rectifying the face presentation. If at this stage, the patient had been put in the knee-elbow or genu-pectoral position the child, by force of gravity, would have fallen towards the fundus and the head obtained relief from the pelvic obstacles productive of or auxilliary in the face presentation. In thus changing the direction of the force of gravity in the child, the head would have fallen forward, bringing the chin to rest on the child's chest. Permitting the woman to remain in this positson until several pains have past, during each of which the accoucheur should convince himself whether the desired change is taking place or has occurred and, if the latter, she may again be placed upon the back; though in this instance he should have preferred to keep her on the right side, from the fact that the back of the child was to the right and anterior, there being a large amount of fluid present a dropping forward of the body of the child would have favored and assisted in the descent of the occiput and thus help in bringing about the position desired.

Dr. Carpenter said, in closing the discussion, that if flexion could have been brought about in the way stated by the last speaker, she regretted that that method had not been tried also.

This was beyond question a case where the face presented before contraction had begun. Examination the day before showed the vertex was not presenting.

Also when summoned to the case and dilatation of two inches had already occurred, it seemed to be due to a relaxation of the parts, as the patient only suspected labor was about to begin. The head was then fully extended.

ACADEMY OF MEDICINE IN IRELAND: OBSTETRICAL SECTION.

Meeting of Friday, March 30, 1883.

J. DENMAN, M.D., President in the Chair.

Dr. R. Henry read a paper on the importance of the

THIRD STAGE OF LABOR.

He commenced by pointing out the various risks, immediate and remote, to which the improper performance of the third stage of labor exposed a woman. These risks would be minimised by a suitable conduction of this most important period of labor. To arrive at any just conclusion on this subject, it was necessary, in the first place, to study Nature's methods in effecting the separation and delivery of the placenta and membranes—by the conjoint action of tonic and clonic contractions moulding the placenta, as had been described by Dr. Matthews Duncan, or in the different way described by Schultze. In the author's experience, both these methods had been observed, a lateral attachment of the placenta being Duncan's, while a fundal or nearly fundal one would give Schultze's. The former was the more common method. Dr. Henry quoted Denman, Smellie, Collins, and others, on the question of manual interference in the third stage. In 1786, Dr. Joseph Clarke had advised the practice of "pursuing with a hand on the abdomen the fundus uteri in its contractions, until the fetus be entirely expelled, and afterwards continuing for some time this pressure, to keep the uterus, if possible, in a contracted state." This practice had been largely adopted in Dublin. Dr. Henry adhered to it, believing that, in modern practice, undue haste to press off the placenta was constantly exhibited. He kept his hand over the uterus during delivery and subsequently, but forbore pressing or actively supporting the uterus until it had itself commenced to contract clonically. Assistance should only be given with the clonic contractions. A safe and permanent contraction, following the expulsion of the secundines, might, in this way, be usually secured in from ten to twenty minutes. The chief error at present consisted in mistaking constant irritation for support of the uterus.

Dr. Denman, the President, said the paper raised several questions of

deep interest, viz., as to the time at which the placenta should be removed; as to the danger on the one hand of being too precipitate, and on the other of leaving the placenta too long; as to how far hemorrhage was sometimes induced by a too speedy removal, and at other times by leaving the placenta too long in the uterus; and also as to the danger of leaving in portions of the membranes.

Dr. Harley objected altogether to premature pressure over the fundus of the uterus for the purpose of pressing on the placenta. He also objected to exercising pressure on the cord at any period.

Dr. W. J. Smyly stated that, in the Strasbourg Hospital, where the patients were, as a rule, left to nature during the third stage of labor, it had been observed that the placenta was most frequently expelled in the manner described by Schultze. He believed that Credè's method of exciting the uterus to contraction had been confounded with the hasty expulsion of the placenta. Credé himself never advocated the immediate expression of the placenta, but rather the immediate excitation of the uterus by irritation and friction through the abdominal walls, and then, usually with the third or fourth contraction, the expression of the after-birth. The immediate expression of the placenta was very liable to be followed by the retention of the membranes and *post partum* hemorrhage.

Dr. Macan said that, since the time of Hippocrates, there had been ebbs and flows of opinion as to whether expulsion of the placenta should be left entirely to nature, or should be immediately effected by the accoucheur, either by passing the hand into the uterus, as the older authorities recommended, or by the more modern treatment of expression. Hence he thought that a happy mean between these two methods was probably the best way; for, if the uterus was well contracted, there need be no fear of hemorrhage, and therefore no cause for hurry; while, if the uterus was relaxed with hemorrhage, the removal of the placenta tended certainly to increase the hemorrhage by removing all pressure from the mouths of the uterine sinuses, unless the means used to remove it at the same time caused the uterus to contract. The great advantage claimed at the present day by the adherents of the plan of leaving the whole process to nature was, that, a much larger proportion of the decidua came away with the placenta than when the placenta was immediately removed. When two such authorities as Dr. Matthews Duncan and Professor Schultze differed as to the mechanism of the separation and expulsion of the placenta, it was pretty certain that there was more than one way, and that both their views were probably right. If they adopted the expression plan, which might, he thought, be called "the Dublin method," they should be careful not to allow the placenta to be suddenly expelled on the bed; for a sudden strain was thus put on the

membranes, and a portion might readily be torn off and left behind in the uterus. This had been looked upon as a very serious accident. But Dr. Macan was inclined to think that the mere presence of a portion of the membranes in the uterus, for some days after delivery, could not be looked on as dangerous, unless air had been allowed to enter and set up decomposition. He also thought that it was very often during the efforts made to remove a piece of retained membrane that the air was caused to enter the uterus. He had often seen a piece of the membrane expelled some days after delivery, without being accompanied with the slightest fetor, or giving rise to the least fever. Indeed, it seemed to him probable that, in hospital practice at least, the danger from retention of a portion of the membrane was less than the danger of infection from the hands of the operator in his efforts to remove it. He always waited a quarter of an hour before attempting to press off the placenta, and considered that light friction over the fundus, with the tips of the fingers, was a much more powerful method of inducing contraction than merely holding the fundus in the hands.—*British Medical Journal.*

PROCEEDINGS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Meeting of June 6th, 1883.

J. M. Keating, M.D., visiting obstetrician to the Philadelphia Hospital and lecturer on diseases of women and children, read the following paper:

Some Observations on the Salivary Digestion of Starch on Infants.

Recently, in a late English work, I find the following: "During the first few months farinaceous food of every kind should be avoided, for the child's stomach (?) cannot digest it. Until the third month, or even later, no saliva is secreted, and without this floury foods cannot be assimilated." (*Management of Infants, etc.*, by Howard Barrett.) This idea is so prevalent, and most of us have adopted the statement as representing the teaching of physiologists, that it has always been a matter of surprise to those interested in the feeding of infants to find occasionally, especially amongs the poorer classes, infants fed upon corn-starch or other farina, almost to the exclusion of other food, and thrive.

At present, we presume that amylaceous material has of necessity to be converted by hydration into glucose, and for this reason I will not detain you this evening by indulging in the more speculative aspect of this subject, as to whether dextrine is capable of being absorbed, and which of the two ferments, that of the salivary glands or of the pancreas, is of the most importance. We have left this matter for further investi-

gation. Prof. Albert R. Leeds, in his very able exposé of the subject of foods as regards chemical constituents, made the matter so clear, that in his table of the analyses we have evidently an accurate guide for the selection of foods in individual cases. But as the general belief is, that for infants of a tender age, our choice should fall on that which contains a minimum quantity of starch and a maximum amount of vegetable albuminoids, or foods based on the Leibig formula, I deemed it valuable to institute a series of experiments, the result of which I confess were rather surprising, to test the saliva of infants, and to satify myself that the reason why some children apparently thrive on starchy food, is not due to any change in the starch in its preparation, but depended upon contact with secretions well established in childhood.

In these tests we endeavored, as far as passible, to exclude all error. Corn-starch was used, it having been previously boiled, cooled into a paste, and portions of this was put into linen bags, aud given to infants to suck for two minutes at a time; Pavy's test was then used; the corn-starch paste exhibited before the experiment no evidence of sugar change.

The linen was thoroughly boiled without discoloration of the solution. The bags with their contents were in each case thrown into a test-tube, and I submit for your examination the accompanying report.

To the resident physicians of the Philadelphia Hospital, Drs. B. F. Hawley and A. E. Roussel, I am indebted for assistance in this matter, as many of these tests were repeated a number of times by them, and great care was used to insure accuracy. My report includes the results obtained by experiments with the saliva of twenty-one children—varying in age from six days to seventeen months. The sugar change was noted in all but three—one of these was a babe six days old—whilst in another babe seven days old a marked reaction was observed. I feel satisfied that some infants do digest starch provided it is presented to them in a digestible form, and also that the salivary secretion which occurs earlier than we have been accustomed to believe, is allowed to come in contact with it, and I cannot but attribute the many statements to the affect that starchy food in small quantities is contraindicated, to the fact that the secretions of the mouth are less liable to exert their influence when such food is administered by bottle and deposited in a surprisingly short time in the acid juices of the stomach. If starchy food, such as barley flour, oatmeal, rice, wheat flour, etc., is indicated on account of its highly nutritious qualities which exist in all portions of the grain and deemed advisable in the feeding of children, our few observations teach us that they should be administered in such a way as to insure their thorough digestion, and I am satisfied that the surprising results we witness, especially among the poor, of thriving table-fed babes, is due to the mode of feeding more than to the fact that they are exceptional and as-

tonishing cases. My table shows that the age of the infant is not a guide to the quality of its saliva, and we should bear this in mind when choosing the form of food. Thus, should we be called upon to regulate an infant's feeding it would be important for us to test the saliva.

If we find a sugar change taking place we might incorporate with milk small quantities of one of the cereals, either barley, oatmeal, or wheat. On the contrary, should the test prove negative Horlick's or Mellin's food would be decidedly preferable. But while thoroughly convinced that the saliva is a most important element in digestion, we cannot overlook the fact that starchy foods have also to run the gauntlet of the pancreas, which organ if it possess in childhood relatively the same power that it does in later years, is far more active than the salivary glands. We cannot then overlook the value of a microscopic examination of the stools of all bottle-fed children, for I believe that by this alone we can regulate the quantity of farinaceous food, detecting the proportion of the undigested residue.

No.	Child's name.	Age.	No. of teeth.	Food.	Reaction.	No. of experiments.
1	Smith.	6 days.	0	Breast.	None.	3
2	Coyle.	7 "	0	Breast.	Marked.	1
3	Gallagher.	11 "	0	Breast.	Well marked.	2
4	Asbulson.	12 "	0	Breast.	Marked.	1
5	Perry.	2 weeks.	0	Breast.	?	1
6	McErwin.	3 "	0	Breast and crackers.	Well marked.	3
7	Meenan.	3 "	0	Bottle.	Perceptible.	2
8	Conner.	4 "	0	Breast.	Marked.	2
9	Davis.	4 "	0	Breast.	Marked.	1
10	Beatty.	4 "	0	Breast.	Very slight.	2
11	Sumler.	4 "	0	Breast.	Marked.	1
12	McCann.	4 "	0	Breast.	Very marked.	1
13	Newhouse.	7 "	0	Breast.	Very slight.	2
14	Roberts	2 mos.	1	Breast.	Marked.	2
15	Nerain.	2 "	0	Breast.	Very marked.	1
16	Boenning.	2 "	0	Breast.	Marked.	1
17	Hemileth.	4 "	2	Corn starch and crackers.	Well marked.	2
18	Roach.	5 "	1	Corn starch and crackers.	Slight.	3
19	Hall.	8 "	2	Breast and crackers.	Marked.	1
20	Devine.	13 "	4	Corn starch and crackers.	Well marked.	1
21	Wood.	17 "		Condensed milk.	None.	

The following are my conclusions :

The saliva of some infants posesses the property of converting starch into glucose regardless of age.

The age of the infants cannot be taken as an indication of this property of its saliva.

When such a condition is found to exist a small quantity of well-prepared farinaceous food is valuable as an element in the diet, incorporated with mixed cow's milk.

An examination of the stools of children so fed, would be a guide as

to the quantity of starchy food to be used, and when farinaceous food is employed slow feeding is probably preferable to the bottle.

Dr. N. A. Randolph, Assistant Demonstrator of Physiology in the University of Pennsylvania, reported the following:

NOTES ON THE FECES OF STARCH-FED INFANTS.

The series of experiments presented in the preceding paper by Dr. Keating seems to me to be in the highest degree suggestive, for it is only rational to suppose that the development of the amylolytic ferment of the pancreatic juice is coincident with the appearance of the analogous salivary ferment. Inasmuch, however, as the food even in spoon-fed infants is retained but a short time in the mouth, and further, as the continued action of the saliva after it enters the stomach is as yet problematical, the only absolute control for such observations is afforded by an examination of the feces.

Through the kindness of Dr. Keating I have been enabled to examine the stools of twenty-four starch-fed infants, of ages varying from forty-five days to eighteen months. Twenty-three of these children were fed upon cracker-dust, water, and condensed milk. The twenty-fourth received corn-starch boiled in milk.

The freshly evacuated feces of each infant were carefully bottled and labelled, and a drop of a solution of iodine was added to a small portion of each specimen, which was then submitted to microscopical examination. Besides turning the starch blue, and indicating the presence of dextrine by a peculiar mahogany-red color, the iodine has the advantage of rendering any fats which may be present much more readily apparent. The reaction of each specimen was taken, but though this varied from acid to alkaline and neutral, no correlation between the reactions and the other properties of the specimens could be observed. A decoction of each was tested for glucose with freshly prepared Fehling's solution, but except in one instance no appreciable amount could be found.

The presence of *starch* was exceptional and apparently in no degree dependent upon the age of the child. The stools of eighteen out of the twenty-four children contained either no starch, or but a trace, *i.e.*, no more than is frequent in the evacuations of a healthy adult upon a mixed diet. Six of these specimens were from children of three months or less, —the youngest being but forty-five days old. In many cases the broken and empty cellulose envelopes of the starch granules were clearly discernible.

The six infants in whose evacuations a noteworthy amount of starch was present were aged respectively three, four, ten, thirteen, fourteen, and seventeen months. The eldest two were in very bad health.

The following is a tabular statement of the age, diet, and appearances of the feces in the children forming the subjects of this study.

AN EXAMINATION OF THE FECES OF TWENTY-FOUR STARCH-FED INFANTS.

No.	Name.	Age.	Food.	Starch present.	Remarks.
1	Savin.	45 days.	Condensed milk, cracker dust.	None.	
2	Jocker.	2 mos.	"	Traces.	
3	McGettinger.	2+"	"	"	
4	McGowan.	3 "	"	"	Twice examined; no fat before inunction, about 10% after.
5	Ross.	3 "	"	"	
6	Hays.	3 "	"	About ½ starch.	
7	Soy.	3 "	"	Traces.	
8	Henwich.	4 "	Corn starch, and milk.	"	
9	Moore.	4 "	Condensed milk, cracker dust.	None.	Many broken cellulose envelopes.
10	Conway.	4+"	"	Traces.	Evidences of potato surreptitiously given.
11	Roach.	5 "	"	About ½ starch.	
12	Anxier.	5+"	"	None.	
13	Schmitz.	5+"	"	"	Many bacteria.
14	McKinley.	6+"	"	"	10% fat; had had inunctions.
15	Hall.	8+"	Breast, and cracker food.	Traces.	
16	Hensen.	10+"	Condensed milk, cracker dust.	More than normal.	Many bacteria; evidences of potato surreptitiously given.
17	Devine.	13—"	"	20 to 30 %.	Some glucose present, indications of dextrine; saliva was found to be inefficient.
18	Croncia.	14—"	"	Traces.	
19	Madden.	14 "	"	"	
20	Boyle.	14 "	"	10% starch.	Sick.
21	Glass.	14+"	"	None.	Except a few large cells containing starch from potato.
22	Kinscher.	17—"	"	"	
23	Wood.	17—"	"	Over ¾ starch.	Syphilitic; saliva was found to be inefficient.
24	Dane.	18—"	"	Traces.	Indications of dextrine.

The facts presented appear to justify the following conclusions:

First, that *many* infants of under three months can digest starchy foods.

Second, that the individual variations in this regard are so numerous that no broad and general statement can be made as to the period at which infants *begin* to digest starches; and

Third, that the physician can be absolutely certain that a farinaceous ingredient in the diet of a young infant is beneficial only by an examination of the dejecta under such diet.

After the reading of the preceding paper:

Dr. Keating spoke of one case in which fat was found in the feces—

cod-liver oil had been administered in the form of inunctions, and the child fed alone on Borden's condensed milk.

Dr. Randolph replied that he had found 10 per cent. of fat in the feces of a child which was receiving two inunctions of cod-liver oil daily. He was now conducting some experiments upon this subject and intended to report the results to the College in a communication to be read at a future day.

Abstracts and Selections.

I.—OBSTETRIC.

The Successful Treatment of Extra-Uterine Pregnancy.—The following report of cases, in which *electro-therapeutics* was employed, is by Dr. A. D. Rockwell, of New York, and appears in the *Medical Record*, February 17, 1883. We reproduce it both for the results obtained as well as for a number of interesting points which present themselves incidentally.

In the first case of extra-uterine pregnancy which it was my fortune to treat, I was asked by Dr. T. G. Thomas, one of the consulting physicians, whether it was possible to readily destroy the life of the fetus by the electric current. I replied that it could undoubtedly be done, but the important question, it seemed to me, was, whether it could be accomplished without injury to the mother. This question was answered in the affirmative by the results that followed. The case was one of tubo-interstitial pregnancy, at the third month, and terminated favorably by the expulsion of the fetus and placenta through the uterus. The history of this interesting and remarkable case was carefully written out by the attending physician, Dr. Charles McBurney, and published in the *New York Medical Journal*, vol. xxii., No. 3. At the same time Dr. Thomas wrote out an interesting description of the case accompanied by illustrative drawings, which he kindly placed at my disposal, and which can be found in my third edition of "Beard and Rockwell's Medical and Surgical Electricity," p. 606.

The second case upon which I operated was in the practice of Dr. C. E. Billington, the accuracy of whose diagnosis was again confirmed by Dr. Thomas. The result in this case was entirely successful.

The third case I treated for Dr. Bache Emmet, who had in consultation both Dr. T. Addis Emmet and Dr. T. G. Thomas. Dr. Emmet's account of the case, with its favorable termination, may be found in the *New York Medical Journal.*

In the fourth case I operated for Dr. Everett Herrick, the diagnosis being doubly confirmed by Drs. Thomas and Emmet. In this case again

the fetus was effectually destroyed, followed by the prompt recovery of the mother.

At the last meeting of the American Gynecological Society of Boston, Dr. T. G. Thomas read an exhaustive paper upon the subject, giving the histories of some twenty cases of extra-uterine pregnancy that had fallen under his observation, together with an account of most of the cases to which I have just alluded, and in which electricity was so successfully used. In addition to these I have more recently seen and operated upon three other cases of like character that have never been reported, and which, if possible, even more strongly confirm the incalculable value of the treatment in these dangerous but somewhat rare abnormalities of pregnancy.

The fifth case, which I saw with Dr. N. S. Westcott, was of a most interesting and unusual character, from the fact that with a normal uterine pregnancy was associated what we have every reason to believe was a tubal or extra-uterine pregnancy. Dr. Westcott had previously called Dr. Thomas in consultation, and it was at his suggestion that electricity was used. The patient, a lady, aged about thirty, last menstruated August 6, 1882. Subsequently she complained of more or less discomfort and pain, with tenderness in the region of both ovaries, but especially marked on the left side. On September 18th an internal examination was made, and by conjoined manipulation a small tumor was discovered about the size of a pullet's egg. It was situated some two inches to the left of the median line, nearly on a level with the brim of the pelvis, and could be moved from Douglas' cul-de-sac toward the margin of the ribs. The tumor gradually increased until it was larger than a billiard-ball. There seemed to be no reasonable doubt as to its character, and on October 24th, the treatment by electricity was attempted.

The constant current was used, with one pole introduced to the mass through the vagina, and the other over the tumor externally and with rapid interruptions. The maximum of current strength employed was eighteen cells, or, to speak more accurately, as different apparatus vary much in electro-motive force, a power of twenty-four volts.

This operation was repeated on October 25th, 28th, and 30th, causing the tumor not only to perceptibly decrease in size, but to change its seat by an inch or so as well. Since the last treatment it has gradually grown smaller, until at the present date it can barely be detected. At the same time there is now developing in the uterus a six months' fœtus.

The sixth case occured in the person of a young unmarried woman residing outside the city limits, and by special request, and for sufficient reasons, the name of the attending physician will not be mentioned. From him I obtained the following history: Two weeks previously he first saw the case professionally, and found that she was suffering much pain in the right side, together with irregular discharges of blood. The

patient had confessed to the possibility of pregnancy, and examination elicited many of the objective and subjective signs of this condition. Nausea occurred every morning, and changes had taken place in the areola. Digital examination revealed the fact that the os uteri was little, if any, changed from its normal condition. By pressure over the right side it was possible to feel a certain hardness not present on the other side, but by conjoined manipulation, with one finger in the vagina a distinct rounded mass could be felt.

Examination per rectum revealed its presence even more distinctly. If pregnancy existed—and of this there seemed to be no reasonable doubt—it had advanced nearly to the fourth month, and as the tumor was large, much larger than in the case just related, there was evidently no time to lose. I had brought with me a suitable apparatus, and immediately operated by introducing one pole into the rectum, and placing the other externally. On account of the great distention of the Fallopian tube, and the danger of rupture, we felt the necessity of exercising the utmost care, and consequently made use of the interruptions, with a current strength of but twelve cells, or about sixteen volts. The current would then be quickly increased without interruption and allowed for a moment to pass in a continuous stream. The treatment was concluded by a second application on the following day. Visiting the patient some two weaks subsequently, I found that the tumor had decreased in size at least one-half, and at this time, after the lapse of several months, it may be said, so far as any external evidence of it is concerned, to have entirely disappeared.

The last case is as follows: On December 14, 1882, I was informed by Dr. H. Marion Sims, that Mrs. A——, a patient of his, was suffering from extra-uterine pregnancy, and was by him requested to undertake the destruction of the fœtus by electricity.

Although married a number of years, she had never before been pregnant. Dr. Sims, on first discovering the probabilities of this condition, called in consultation Dr. T. Addis Emmet, who positively confirmed the diagnosis. The pregnancy had advanced to the third month, and the tumor, which was about the size of a child's fist, was movable and could be distinctly felt both from without and within.

The size of the enlargement was such that the operation was urged immediately. For fear that the cyst might be in danger of rupture through uncontrollable movements of the patient, Dr. Emmet advised the administration of an anæsthetic.

Ether having been given by Dr. M. H. Nash, Dr. Sims placed the uterine electrode, and shocks from a galvanic current of but sixteen volts in strength were passed through the fœtal mass.

The mildness of the treatment was necessitated because of the unusual nerve-irritability, and the violence of the muscular contractions.

Although it was probable that the destruction of the fœtal life had been affected at the first seance, the operation was repeated on the 18th, 24th, and 27th of December, for the purpose, first, of absolute certainty, and second, to accelerate the absorptive process. The contour and seat of the tumor were not only changed after the first application, but it rapidly decreased in size. The patient experienced no unpleasant effects, and within a short time was able to start for Europe.

In the treatment of extra-uterine pregnancy, it is an important point to be decided, as to the best form of electricity to be used. Not only has galvanism and electro-magnetism been successfully employed, but it is said that the common magneto-electric battery has also proved sufficient, but from both a physical and physiological point of view, and as well through the teachings of experience, I cannot, for my part, doubt that galvanism is preferable to the other forms. It is more certain in its effects. It has a greater power of overcoming resistance, and consequently its influence is felt deeper than the other forms. Four important effects attend the passage of the electric current through the living body, and all these undoubtedly enter as factors, either in destroying the life of the fœtus, or in the subsequent process of absorption.

These effects may be designated as mechanical, physical, chemical, and physiological.

The mechanical effects of the interrupted galvanic current are equal to those of the faradic current, while the physical effects, manifested by heat, and the modification of endosmose and exosmose are in the main the results of galvanic action.

By the passage of the galvanic current, the endosmotic phenomena may be both stimulated and reversed. The faradic current from the secondary coil produces no such effect. The current from the inner coil, produces these effects, but in a much less degree. Chemical or electrolytic effects, again, are almost wholly the result of galvanic action, and it should be remembered that the electrolysis of organic substances starts a process that continues long after the current ceases to flow. The physiological effects of electricity are those which take place by virtue of the vital properties of the body, and unlike the other effects, are only observed in living substances. Physiological effects are manifested on the circulation, on secretion and excretion, but only as absorption is effected does it interest us here, and it is quite evident that the absorptive powers of the secondary current are quite limited.

In any case of tubal pregnancy, and especially in those advanced conditions where the tube is greatly distended, and there is danger of spontaneous rupture, the possibility of hastening this catastrophe in the attempt to destroy the life of the fœtus should never be lost sight of. The tubes themselves are but slightly supplied with muscular fibre, and the danger would more especially arise from the powerful compression that

is liable to be exerted by the abdominal muscles, and the effort should be so to diffuse the current proceeding from the external pole, as to produce the least mechanical effect possible. In regard to the diagnosis of extra-uterine pregnancy, it must be confessed that it is not always an easy matter, and in the cases just related the question may arise as to its accuracy. The eminence of the gentlemen associated in the cases should perhaps be a sufficiently strong argument for the correctness of the diagnosis, but conclusive evidence lies also in the effects of the treatment itself. The results of the electrolysis are well known, but in no other form of tumor, cystic or otherwise, is it possible for the galvanic current, used as described, to produce similarly prompt and effective results. In regard to the effects of electricity on normal pregnancy, suggested by the case of double pregnancy that I have related, a word may be said. It is a mistake to suppose that abortions are readily produced by electricity. Without the electrode is introduced directly into the uterus, which would of course be sufficient without the passage of any current, the strongest treatment that it is prudent to give may prove insufficient. Of this I have had evidence in several justifiable attempts to bring on a miscarriage. In the case just alluded to the current was strong, applied by shocks, and in close proximity to the uterus, affecting it not only reflexly, but in some measure directly, yet the normal pregnancy was in no ways disturbed; and, so far as concerns general application for the production of constitutional tonic effects, I have in many instances adminstered them with impunity through the whole course of gestation, and with the most happy results.

Modern Obstetrics.—An address delivered at the annual meeting of the Yorkshire Branch, by J. H. KEELING, M.D., F.R.C.S., Surgeon to the Jessop Hospital for Women, and to the Sheffield Public Hospital and Dispensary, and published in the *British Medical Journal.*

Acknowledged talent, or respectable seniority, is the *ultima ratio* which guides us in the choice of a president for this and similar societies. The talented ones are few in number; the recognition of their gifts is slow; hence the advantage of having a second class from which to choose in case of need. Were talent and attainment the sole admissible qualification, the large majority of us would be hopelessly excluded. As it is, all things come to him who can wait, and any of us may hope in time to acquire such age and respectability as will lead to the presidency, should there happen to be a dearth of other and more valid claims. In the name of the respectable seniors I beg to thank you, very heartily, for the honor you have done them and me in choosing a president from their ranks, and to express a hope that, as the alternative of choice which puts them in possession is only an occasional one, the *prestige* of the chair will not thereby be seriously diminished.

Some philosophers assert that man has won his supremacy in the animal kingdom mainly by the saving grace of speech; by his superior power of communicating and perpetuating his slowly increasing stock of knowledge. To whatever extent heredity and surrounding circumstances might develope the admirable instincts of contemporaneous animals, they were ultimately left far behind in the race with man; because he alone, or in a far higher degree than they, could accumulate knowledge, diffuse it readily through the primitive communities which his gregarious nature led him to form, and hand it down to his successors as a starting point for further accretion. Be this theory of olden time a tenable one or not, it is unnecessary, in modern days, to dwell on the advantages which men medical or otherwise, gain by taking counsel together. For ourselves—by associated work in our hospitals; by the joint labor of a teeming medical press, luxuriant to rankness if you like, but intensely vital; in our various societies, haunted though they be by repetition and commonplace, we have an admirable apparatus for increasing, spreading, and perpetuating our store of information.

In this way, conjoint work has a twofold value. For, whilst it aids in the discharge of a duty which each medical generation undoubtedly owes to its successor – that of handing down an unimpaired, and, if possible, extended heritage of knowledge—it serves the more imperative and immediate purpose of bettering the equipment of all who are daily battling with disease and death. In fulfilling the latter object, there can be no doubt of the value of societies such as this. Where else shall we find so easy and pleasant a discipline; where, so varied and interesting supply of information? There is always some uneasy, ardent, soul at work, tilling a corner of the medical vineyard, and inviting us to share the fruits of labor which we have been too tired, too lazy, or too dull to share. There is always an indulgent, sympathetic audience for the young member, who can back his careful notation by a good pathological specimen. Disease is no respector of persons; in his early days he may chance on a morbid product in every way presentable. However unprofitable in the way of pelf, his field of observation is generally large and miscellaneous enough to furnish matter worthy of at least a passing record. Though he may have misgivings as to the value of his work to others, of one thing he may rest assured, viz., that in preparing a paper or case, or in noting the points in a specimen, he, at least, is a gainer; his own wits, at any rate, have been sharpened; those of others also, but he must not expect to hear of it.

The well-found practiced observer can take care of himself; in the meantime, he is none the worse for the good-humored criticism of a competent audience. Human nature, in its abounding conceit, ever needs a mentor to recall it to a juster and more modest estimate of its achievements. Even the work of our experts is the better for challenge and

scrutiny. As to the greyheaded veteran, listening with sceptical interest to some new and erroneous view of an old topic, or noting the weak point in a novel attack on some ancient malady, he, too, finds his account in being present; for, whether he gains new light for himself, or mercifully helps in the general interest to extinguish a misleading will-o'-the-wisp; whether he witnesses some practical advance, or merely wiles away an hour in nodding to old acquaintances in the pathological tray; if he would keep clear of the mildew and rust of old age, he will do well to frequent the gatherings of his younger and more active friends.

In our provincial and local meetings, we cannot of course expect the keen discussion of advanced points, the exhaustive inquiries into special topics, which characterise metropolitan societies. Our *role* is an humbler one; I venture, however, to think that, within its proper range, it is equally useful. As an electrician gains intensity by adding cell to cell, so does advantage result from the direction into a given channel of a number of intellects, even though none be of the highest order. What the Royal Medico-Chirurgical, the Pathological, the Obstetric Societies are to leading spirits and special departments, such are local and provincial meetings to the rank and file of the profession—illustrative of, and helpful in the daily emergencies of practice. In this way, our meetings form trysts, which no one can leave without feeling that a stimulus has been applied, impelling him to fresh and clearer thought, and investing with renewed interest the task of his daily life.

Whilst our Association thus affords, in the meetings of its various Branches, recurring opportunities for the exchange of scientific thought and the promotion of good fellowship, it has imparted a unity, and power of combined action, to the profession, which it did not previously possess. This has already been repeatedly manifest, and will become more and more evident as the Association gains in numbers and cohesion. As yet, I think we scarcely realize, and certainly do not fully use, the advantages which combination on a large scale brings with it. Much energy and time have necessarily been consumed in the detail of organization. Now and then, the distribution of place, rank, and office has created heart-burning, and the tumultuous young blood amongst us has grown restive under the guidance of those who have witnessed the birth, and fostered the life of the Association. These ephemeral disorders are inevitable; in time, they will right themselves. We shall all be glad when our growing power and funds can be directed more definitely and exclusively to objects of common professional interest. Amongst these may be named the simplification and reduction of our absurd system of degrees and qualifications; the fostering of scientific inquiry by grants, prizes, and collective investigation; the combination for mutual defense and succor against quackery, adverse legislation, and poverty. We have, of course, standing committees whose object is to

promote effort in these directions, but the interest of the members, as a whole, is by no means roused. When this has been effected, we shall find in our Association an instrument of great power in raising the status of the profession, both in its collective and individual aspects.

The address with which we commence the business of the year has one excellent peculiarity; it is exempt from discussion. The speaker is free to propound truth or heresy, to indulge in vague generalities, or trot out a favorite hobby. All is forgiven him, even dulness, provided only he be brief. On past occasions, whilst medical and surgical topics have received becoming attention, the ladies, I think, have not. I venture, therefore, to-day, to detain you in the department of obstetrics, whilst we glance briefly at a few of its salient and, I trust, progressive points.

Some, no doubt, will murmur. Fancy, out for a sort of half-holiday in the warm summer-time, and led back to our galley-oar in the lying-in room! Surely the mine is worked out. It is well known that every accoucheur is a past master at thirty, and needs naught but his own experience to draw upon. Let but a midwifery topic be introduced, and mark how each man will tell you what he has seen, and the marvels he has wrought.

Well, is the mine worked out? Are we really without hope or need of further advancement, where Smellie and Blundell and Ramsbotham left us? Surely not, with that big mortality bill, which includes one in one hundred and twenty of all women giving birth to children. Certainly not, so long as we are harassed by those qualms of conscience which the best of us have felt when a valuable life has passed through our fingers, at a moment when its value was more than ever apparent.

Promising all malcontents that labor shall be rapid and bristling with complications, permit me, first of all, a few words on the plague which haunts the whole domain of midwifery—*puerperal or childbed fever*—that factor which more than any other, by its frequency and fatal character, justifies the proverb of our German neighbors, "A lying-in woman has already one foot in the grave." Do we know more about it than we did? Can we treat it, or ward it off more effectually?

The old notion of this disease, or group of diseases, is embodied in the definition published in the nomenclature of the Royal College of Physicians: "A continued fever, communicable by contagion, occurring in women after childbirth, and often associated with extensive local lesions, especially of the uterine system." The new notion is, that it is no fever at all in the true sense of the word; that the "extensive local lesions" are at the bottom of the mischief: that the metritis, peritonitis, phlebitis, cellulitis, lymphangitis, or whatever "itis" or "æmia" the unlucky certifier may choose, under which to mask the cause of that death in childbed which he has just had to report to the registrar—that all these condi-

tions simply mark the track taken by a septic poison arising in, or introduced into, the parturient canal during or after labor.

And thus we have this formidable malady relegated to the same class as the septicæmic and pyæmic complications of general surgery, and we look to the same means of redress. Where shall we find, in the whole range of surgical accident or disease, a more ingenious arrangement for septic mischief than that which results from difficult and protracted labor? Think of the lymphatics of the uterus, enlarged by pregnancy, ready for their beneficient work in the involution of that organ, but ready also to take up the decomposing secretions of the bruised, abraded, lacerated tract, in and around which they lie. Think of the huge, blind-ended, deeply hidden sinus formed by the parturient canal—no; not a sinus, guarded as this often is by a barrier of protecting lymph, but a tunnel with damaged walls, pierced far down by treacherous badly closed apertures through which disease-spreading germs and infecting ichor may make their way, along veins, lymphatics, and connective tissue, into the system of their unfortunate proprietor. And then the general condition of the patient—emaciated by pregnancy, fatigued to the last degree by recent suffering, and often enough with kidneys embarrassed in a way which will be a dread in the candidate for an ordinary surgical operation. How do we deal, in general surgery, with a mischief-breeding tract such as I have descrbed? Cleanse, drain, prevent the entrance of septic poison from without; destroy it, if it arise within. Similar measures are becoming the watchword of modern obstetrics. Our safety lies in fastidious surgical cleanliness of patient, nurse and doctor. Whether we adopt the fashionable antiseptic creed, or think that the bubble has been pricked by a Birmingham pin; whether we believe the cause of the mischief to be the dirt itself or the dirt-loving bacteria, we are coming to see that all must be scrupulously banished, and we are inquiring with increasing care into the best way of accomplishing this. One man trusts to soap and water, another swears by Condy's fluid or carbolic acid, a third shuts his eyes and takes a bath of iodine in his—well, in the smallest and handiest room of his house. The occasional value, in medicine, of a little hocus-pocus has been recognized ever since the days of Naaman. There are people who will wash in carbolic acid and water who will not wash in Jordan.

I am quite aware that a few of our leading obstetricians do not yet fully accept the septic theory of puerperal fever; that its contagiousness is urged, and its liability to be mixed up with erysipelas, scarlet fever, and other zymotic diseases. Let us see how far such objections hold good in the domain of general surgery.

What becomes of a surgical ward which gets overcrowded, or is used too long; when stumps grow septic, healing wounds reddened and loosened by erysipelas, or when scarlet fever creeps in to undo our pet resec-

tions? The inmates are liable to die poisoned, just as they do in an unhealthy lying-in ward. Making allowance for the presence in the latter of half-a-dozen of those interesting but dirty little animals called babies; bearing in mind differences in surroundings, and differences in the anatomy of the parts concerned, I believe there to be the strictest analogy between the causes of death in the two instances.

The most recent, and in every way the best classification of cases of puerperal fever, is into those by *auto-infection*, and those by *hetero-infection*. Now, does not such a classification hold equally good for a group of surgical cases going wrong? *Auto-infection*, where decomposing pus, or serum, or serum, or urine, is shut up in contact with living tissues; *hetero-infection*, by means of a careless dressing, the dirty teeth of a saw, or a hand still redolent of yesterday's post-mortem. Can you suggest a more humiliating record than the one we should have if the recording angel would tell us how many men and women have been killed, in pre-Listerian days, by dirty sponges alone?

If surgical and obstetric poisoning be thus strictly analogous in their causation, so, also, are they in their antidote. For both, disinfection, isolation, and rigid cleanliness.

When the idea has fairly taken possession of the professional mind, as I believe it will, that the phenomena of puerperal fever are mainly the surgical sequelæ of labor; when a more rigid antiseptic procedure has been introduced into the lying-in chamber, whether in the mansion or cottage; when the dirty, ignorant, "Sairey Gamp" type of midwife has been suppressed (of which there is now happily a prospect), and replaced by a trained woman, whose first lesson, for herself and her clients, is "Wash, and be clean"—we shall have a marked diminution in the death-bill of the first four weeks following labor.

There is even just a fear that, in adopting the newer view, we are in danger of forgetting that our old enemy has not changed his nature or tactics, but only his name. "This is a case of puerperal fever," said a medical friend to me lately, "but I think it is caused by a foul drain just outside." Good; we accept the drain-theory, if only it be recognized that the most dangerous part of the drain is its proximal end, the inside of the vagina and uterus. "Not puerperal fever," was the remark on another case, "but pyæmia following labor." "Not lying-in fever, I think," said a friend in another instance, "but blood-poisoning." Now, we do not care very much what the thing is called. By any other name it would stink as badly, and kill as certainly. Let us only beware of being lulled into a false security by a change of name; let us use the fresh light, which this change indicates, in contending with an old and dangerous foe.

Leaving, now, our septic theory to its fate, there are other points in

obstetrics where recent and useful work has been done; time, however, is pressing, and a mere glance must suffice.

In spite, then, of their fearful nomenclature, we have gained in our knowledge of distortions of the pelvis; we have a clearer appreciation of the condition of the uterus in obstructed labor, and the dangers which this condition implies; we have gained in the more frequent and earlier use of the forceps; in our safer management of the third stage of labor; in our extended use of version, especially as an alternative to high forceps operations; in our notions as to when and how to induce premature labor; in our methods of dealing with hemorrhage, whether concealed, inevitable, or *post partum*; in our knowledge of missed labor and extra-uterine fœtation; in our acquaintance with puerperal eclampsia, embolism, and thrombosis. When we are compelled to sacrifice the child, we do our spiriting, so far as the mother is concerned, more gently and quickly. When we decide to give the child a chance by submitting the mother to the knife, it is no longer the classical Cæsarean section which forms our sole resource. We have now the promising alternative of Porro's operation, and possibly that of laparo-elytrotomy. If even we choose to abide by the ancient section, it is not unlikely that, by earlier operation and careful antiseptic measures, we shall rob it of some, at least, of its hoary and evil reputation. Finally, we have learnt to distinguish between surgical and obstetric anesthesia, and when we have safely delivered our sleeping patient without checking her pains or involving her in hemorrhage, we stitch up, there and then, any unlucky tear in the perineum (if our patient be in America, any tear also there may be in the cervix), and we complete our task by feeding her better than our forefathers did, and by a more wholesome and common-sense management of her surroundings. In all these points I think we have advanced. There is not one of them, however, nor are many put together, so important in the lessening of maternal mortality, as the exclusion of that septic mischief, which is the foe alike of the simplest and most difficult parturition.

Permit me, gentlemen, to glance very briefly at one or two points presented by that young and vigorous branch of obstetrics—gynecology. Profiting, in common with general surgery, from the benficient aid of anæsthesia and antiseptics, the surgery of the female pelvic organs has been pushed forward with a rapidity bordering on rashness, but justified by signal success. Here surely the same thought will be the first to occur to many of us; namely, that in this department has been won the brightest and most complete triumph of modern surgery. I allude, of course, to ovariotomy.

Some of us are old enough to remember, thirty years ago, the earnest pleading of such men as Sir James Simpson, when ovariotomies were counted by the dozen, and their mortality anxiously compared with

that of amputation of the thigh. "Fellows like you should simply be handed over to the Public Prosecutor," was the half-angry, half-kindly remark of Mr. Syme to his old favorite house-surgeon, Keith, when this now eminent operator was commencing a work destined to become so brilliant. In London, the storm of opposition was so violent as to drive one or two of the pioneers, bruised and battered from the field. Exploratory incisions, now regarded as a legitimate diagnostic procedure, were pounced upon, dragged to the light, and branded as murderous. Amidst the turmoil and fray a man arose, plucky, skillful, resolute above his fellows, determined to solve the question in dispute, and soon confident of his power to do so. As his numbers rolled up, and his mortality steadily diminished, the thunderous opposition died away in a distant growl. Fellow laborers took fresh heart; imitators sprang up on all sides; distinguished men from France, Germany, Russia, Italy, and America came and sat at his feet; then followed scientific honors, social distinction, and wealth; at last, amid the acclaims of the whole profession, a baronetcy has been conferred on him by his Sovereign, for whose sex he had done more than any man living. Those marvellous lists will be for ever one of the brightest records in the annals of surgery, and the domain which Spencer Wells has done so much to conquer for us, will remain fruitful of blessings to the end of time.

Good work of this kind is essentially pregnant with further gain. In groping amongst the bosses of ovarian tumors, separating adhesions and peeling off clinging viscera, the old fear of operations involving the peritoneum has vanished, and we now handle this once dreaded membrane with as little ceremony as serves us when we deal with the pleural cavity as with an abscess, or fill the knee-joint with bone-dust and blood. Our periodic literature teems with evidence of gain in this direction, but I will cull only from our midst. Not long ago we had, from Huddersfield, an example of the removal of the cancerous pylorus of the stomach; a new and bold operation which, in its design and execution, has certainly been aided by the impunity of previous rambles in the abdomen. At our last meeting we had, also from Huddersfield, an admirable illustration of peritoneal surgery; and our President capped the tale, by relating how an inevitably incised bladder failed to hinder the successful result of a difficult operation. Not very long ago, I was unlucky enough to tear open the colon to the extent of more than two inches, in attempting to detach a firmly adherent tumor. The rent was sewn up, a cyst or two tapped, and then, with her operation abandoned, the patient was carried off to her bed to die. Nothing of the sort. She recovered from her mauling rapidly, full of that pathetic, ignorant, gratitude which now and then rewards very blundering work. A few months later, *post mortem* examination revealed a mere faint line at the point where the bowel had been torn. Last summer, in attacking a doubtful abdominal tumor,

we found that, instead of an ovarian, we had a cystic tumor of the kidney to deal with. The tumor was extirpated, and the patient made a good recovery; thus another gain was added to the many which have followed in the wake of ovariotomy. A few weeks ago, one of my colleagues delivered a woman of a heap of fœtal bones and a hatful of stinking pus, by abdominal incision; the patient is now walking about quite well. Such cases could easily be multiplied, but this is needless; most of us will probably admit that abdominal surgery, in its recent and rapid advancement, owes much to the operative treatment of organs which ought to be, and once were, tenants of the female pelvis.

From ovarian to uterine tumors the step is short and natural. Already the latter are beginning to fall before the knife of the surgeon; and, though we can never hope for the same success with them as with their predecessors, we must remember that effort in this direction is as yet tentative and young. And then those tempting side-curtains and tasselled fringes of the uterus, which carry in their folds so much of the happiness and woe of human kind; can we not remove them with safety when, through disease they have cast a vicious blight over the physical and moral nature of our patients? Can we not, by their simple ablation, put an end, in certain cases, to death-threatening hemorrhage from all uterine fibroids? Dr. Battey and his followers think so. By-and-by, when time and experience have shed their sobering light on the venture, we shall find, as usual, a solid residuum of truth in a practice which is as yet in its experimental stage.

Our fair friends are so much the votaries and victims of fashion, that we cannot be surprised if fashion has invaded even the sacred precincts of the uterus. "Propter uterum mulier est, quod est," has been the cry, whilst the conservative and physiological school has contended with the mechanical school for the possession of that valuable organ. Thus, when Dr. Henry Bennet had fought his way with speculum and porte-castique, and won the ground for congestion, ulcer, and erosion, he had in his turn to yield to a band, armed with pessary and sound, whose cry was all for flexions and displacements; and now these men in possession are threatened by American competitors, who brandish curiously shaped needles, and swear by lacerations of the cervix and ectropion.

For my part, I like those free lances who break away from traditions and explore new paths. Let each mount his hobby—be it cautery, intra-uterine stem, or cleverly devised needle—and let us see who will ride further and best. Should any one, in his eagerness, deviate on to the forbidden ground of vivisection, his good intentions, and the warning afforded to others, shall serve to absolve him.

Amidst these changing problems and their varying solutions, there remains one, sphinx-like in its mystery and mournfulness, which has hitherto baffled the keenest brain and most dextrous hand. Not long ago,

the medical atmosphere was charged with the fragrance of a resinous balm destined, as was fondly hoped, to heal our wounded sisters who were suffering under the cursed malady of which I allude. But time passed, hopes were disappointed, and now the remedy has disappeared in the limbo of forgotten panaceas. Nor has the knife as yet done much for us. Cancer, wherever it can be reached, demands, as our only reliable remedy, the early and unspairing use of the knife. By the time the diagnosis has been established, the chance of successful interference has well-nigh slipped past. Here, the organ it loves to attack is so hidden, so closely connected with bowel, bladder, and ureter, the early inroads of the malady are so reluctantly made known, that, when at last the surgeon is consulted, he has to pronounce the verdict—"Too late," and can occupy himself only in finding for his patient the gentlest and easiest path to the grave. In view of the necessity for wide removal of the disease, complete extirpation of the uterus was long ago proposed, and in numerous instances has been carried out—through the vagina, or by abdominal incision. Frend, Billroth, Schröder, Martini, and others, have been working at the subject of late; as yet, however, without any marked success. Let us hope that another operation of patients and their doctors will have a better tale to tell.

Perhaps the general diffusion of a knowledge of women's diseases is even more noticeable than its increase. The speculum and sound have now definitely taken their place in the *armamentarium of* the general practitioner, by the side of the stethoscope and thermometer, the probe, and the catheter. Compare the position of our younger men with that of the greybeards, when they were young. The abundant supply of admirable text-books, the marvellous variety of instruments of research and treatment, the fierce uterine impregnation of our hospital teaching and periodic literature—all this is very new, all of it very useful, if only we can retain a healthy sense of due proportion and fitness. The result of it all is, that the young men of the present day are in a far better position for dealing with the diseases of women than their predecessors of twenty-five years ago were.

Will you pardon me an illustration? A short time since, I was called to see a case of pelvic tumor with a younger practitioner. He had been summoned the day before to see the woman, who was suffering from retention of urine. Excepting this, and some previous slighter difficulty in micturition, the patient was apparently in good health, and able to follow a laborious occupation. Having relieved the bladder, the doctor proceeded to inquire into the cause of retention, and found a pelvic tumor of considerable size pressing on the urethra and lower part of the bladder. Next day, on seeing the case with him, I found—and this is my point—a full and careful diagnosis ready to hand. The relations, size, and position of the tumor had been ascertained, its probable character

and degree of mobility estimated; the widely separated uterus had been found, and the fact determined that it was but little connected with the growth; the amount of pressure on the rectum had been inquired into; in a word, a tolerably complete and searching examination of the pelvic viscera had been made, and the conclusion arrived at that the case was one of solid ovarian tumor, still in the pelvis, and growing from the left side. My examination confirmed all these points, and there remained only to discuss the line of treatment; but this is a question taxing the brains of men who are in the very first rank of obstetric specialists. Observe, this is an examination conducted, and a diagnosis made, by a junior. The case was not so very difficult to unravel as some, but this much is certain: at his age I could not have done what he did, nor would it have been within the range of the great majority of my contemporaries. Such knowledge and skill did not, as a rule, exist among us; now it is, or may become by a little application, a common possession; for my colleague is no hospital man, simply a general practitioner who uses his brains and the light of modern research to guide him.

In concluding this hasty and imperfect sketch, I think we may venture to affirm that, whilst medicine proper and surgery have rendered invaluable aid to the sister department of obstetrics, they have found in her an ally in every way worthy of the rank to which she has been raised. That brimming bucket of wisdom, laboriously drawn up from the well of truth by Sir "Dispenser" Wells, as depicted recently by *Punch* in his clever and kindly portraiture, would alone entitle her to respectful consideration. The progress of medicine is at best slow and hesitating; problems old as the hills are still unsolved; gain in pathological knowledge too often entails loss in cherished treatment; new discoveries are apt to prove fallacious, and new remedies delusions. All this is true and trite enough. And yet, in the never resting spirit of inquiry which animates all departments of medicine, in the ready light and aid they mutually render, we claim to possess a sure guarantee for further advance in the worth and usefulness of that profession to which, with all its drawbacks, we are proud to belong.

Some Remarks on Puerperal Eclampsia.—By J. E. BURTON, L.R.C.P., Lond., in *Medical Press and Circular.*

In commencing a paper on this subject it seems very desirable at the outset to fix in our minds what we mean by the name we employ. In the following remarks I shall take the term puerperal eclampsia to be any convulsion coming on during pregnancy, labor, or child-bed attended with loss of consciousness, provided it is not apoplectic, epileptic, hysterical, or anæmic, *i.e.*, that it is not the convulsion that comes on in death from hemorrhage just as the individual is *in articulo mortis.*

The causes of puerperal eclampsia remained in darkness till 1842, when

Dr. John C. W. Lever had the honor of first drawing attention to the relations between albuminuria and puerperal eclampsia in Guy's Hospital Reports. In 1851 Frerichs pointed out the resemblance between puerperal eclampsia and uræmic convulsions, and gave his opinion that "true eclampsia occurs only in women suffering from albuminuria." In 1857 Karl Braun, of Vienna, published his classical "Lehrbuch der Geburtshülfe," and ever since that time the exhaustive chapters on puerperal convulsions contained in that work have been the well whence author after author has drawn his modicum of information. I am not aware that a second edition of this work has been published, so that I do not know how far his present views agree with those expressed in 1857. We may presume, however, that they have not altered materially, for his colleague, Prof. Späth, during the course of a clinical lecture in the early part of last year on a case of eclampsia, mentioned no other views than those expressed by Braun in 1857, and said that "the views of gynæcologists as to the origin of convulsions were still hazy;" whilst Braun himself, in a still more recent lecture on a case of albuminuria with dropsy and gangrene of the labia (but without convulsions) makes no mention of any new opinions. We may say, then, that the teaching for the last quarter of a century has been that in the vast majority of cases so-called puerperal convulsions are accompanied by albumen in the urine of the patient, and that this albumen stands in some obscure causal relation to the convulsions. I need not mention the names of many writers. Braun, on page 458 of his work, calls eclampsia "only a partial symptom of another disease" (*nur Theilerscheinung einer änderweitigen Krankheit*). On page 465 he says; "Several years ago I came to the conclusion that acute Bright's disease and uræmic intoxication of the blood are the cause, and not the effect, of the eclampsia." Frerichs followed Brown, and having discovered carbonate of ammonia in the blood of the patient suffering from puerperal convulsions, he concluded that the eclampsia was caused by the carbonate of ammonia, and that this originated in decomposition within the blood of retained urea. Braun himself seems to have accepted this theory in part, and, acting on it, treated sixteen consecutive cases with acids and chloroform, and in every case with success. Murphy, of Sunderland, in an able paper on the subject, goes so far as to make albuminuria the pathognomonic symptom of the disease, and to exclude from the category all those cases in which albumen cannot be discovered. Lusk says that it is the renal insufficiency, and not the albuminuria, that is the cause of the convulsions, and seems to argue from the convulsions, a necessary renal insufficiency as the cause of them. Leishman under the term includes all cases of convulsions occurring during pregnancy, labor, and after delivery. He says; "Epilepsy is to be distinguished partly by the symptoms, but more particularly and conclusively by the absence of albumen in the urine. With rare exceptions, then, puerperal

eclampsia may be looked upon as being essentially connected with, or dependent upon, an albuminous condition of the urine."

Galabin saw 37 cases, and examined the urine in 22, finding albumen in all but one. In 3 out of the 21, however, the albumen was only found after the convulsions commenced.

According to the generally-accepted view, then, the sequence of events in puerperal convulsions is as follows:—

1. Pregnancy; 2. Pressure on the renal veins by the gravid uterus; 3. Parenchymatous nephritis (acute Bright's disease of Braun); 4. Uræmia, originating in some obscure manner (5) the convulsions; but whether by carbonate of ammonia poisoning, or by hydræmia, or œdema, or by retention of the general urinary excretory products, has never been settled to the satisfaction of all parties.

From the time of Braun's first publication, however, there have always been opponents to the uræmic theory of convulsions, men who have been quick to detect its weak points, and to seize hold of any fact that might be made to tell against it. Such a man was Seyfert, of Prague, the director of a huge lying-in hospital of that city. Lusk tells us that he opposed the uræmic theory on the ground of the following facts:—

1. That convulsion may occur without albuminuria; 2. That albuminuria is in many cases the effect, and not the cause; 3. That in many fatal cases the kidney lesions were absent or wholly insignificant; 4. That convulsions are rare in chronic Bright's disease that has existed prior to pregnancy; 5. That in true uræmia, such as is necessarily produced by the suppression of urine, when the ureters are invaded, convulsions do not occur. Dr. Lusk very pertinently replies to the first proposition that it is the renal insufficiency or incompetency, and not the albuminuria, that is the cause of the convulsions. It is now recognized on nearly all sides that convulsions may and do occur without albuminuria; Dr. Lusk even goes further, and acknowledges puerperal convulsions without uræmia or renal incompetency: "Without uræmia puerperal irritation can provoke eclampsia." Murphy, of Sunderland, and Leishman, on the other hand, get rid of this objection (the first of Seyfert) by declining to acknowledge convulsions as puerperal unless they are accompanied by albuminuria. The latter calls these cases epileptic, and tells us that "the absence of albumen will enable us without difficulty to discriminate," *i.e.*, between puerperal convulsions and epilepsy. Notwithstanding that he has shown us a royal or easy method of distinguishing between two diseases with somewhat similiar symptoms, caution comes into play, and he finds it advisable to hedge a little. He says "no one can take a clear and comprehensive view of the pathology" of the subject "who does not freely admit that there are cases in which no uræmic poison exists." He first tells us that we can distinguish epilepsy from puerperal convulsions by the absence of albuminuria in the former,

and next that puerperal convulsions can occur not only without albuminuria, but without uræmia, for albuminuria is of course nothing at all if it is not a symptom of an entirely distinct morbid condition—uræmia.

Playfair, who does not seem at all wedded to the uræmia theory, says: "It may be taken as proved that albuminuria is by no means necessarily accompanied by eclampsia. Cases were observed in which the albumen only appeared after the convulsion, and in these it was evident that the retention of urinary elements could not have been the cause of the attack." He goes on to quote from Braxton Hicks, that the two are almost invariably combined, and that the nearly simultaneous appearance of the two, albuminuria and convulsions, must be explained in one of three ways:—

1. That the convulsion is the cause of the nephritis.

2. That the two are produced by the same cause—viz., some detrimental ingredient in the blood.

3. That the highly congested venous condition induced by spasm of the glottis is able to produce the kidney complication.

After consideration the remainder of Seyfert's objections to the uræmic theory, I shall return for a moment to Playfair and Hicks.

Seyfert's second objection is nearly identical with Hicks' explanations Nos. 1 and 3—viz., that the convulsion is in many cases the cause, and not the effect.

Believing that puerperal convulsions and epilepsy spring from essentially the same causes, I have endeavored to learn whether epilepsy is ever the cause of albuminuria. Saundby examined the urine of a great many epileptics, both before and after the fits, and concluded that the attacks did not cause albuminuria. Professor Fiori, of the University of Cagliari, in a great number of epileptics, not only met with albumen, but hyaline cylinders and sugar. It was found also in animals rendered epileptic by Faradisation. He says, however, that the excretion of albumen was only transitory, and limited to the first moments after the attacks. Klewdgen examined the urine in 36 male and 21 female epileptics, always within four hours of an attack, and found albumen. In many cases the reaction was very slight, and only rarely was there any deposit. He soon extended his researches to the attendants, and, singularly enough, found traces of albumen in *their* urine, and finally concluded that there is nothing remarkable in post-epileptic urine. It appears to me that Fiori's statements require revision. They should either be confirmed or contradicted authoritatively. At present the statements of the three inquirers as to whether convulsions can produce albuminuria are contradictory, but I think the evidence upon the whole points to the conclusion that they cannot.

The third and fourth objections of Seyfert—viz., that in many fatal cases the kidney lesions were absent or wholly insignificant, and that

convulsions are rare in chronic Bright's disease that has existed prior to pregnancy—are substantial ones, and are valid arguments against the uræmic theory. The fifth is also a valid one—viz., that in true uræmia, such as is necessarily produced by the suppression of urine when the ureters are invaded, convulsions do not occur. Cornil and Ranvier confirm the truth of this statement in an emphatic manner, and say that in no instance had convulsions taken place. I myself am able to verify this statement, or, to put it more correctly, in fatal cases of uterine cancer in which I have had reason to suspect occlusion of the ureters to be the immediate cause of death, although I have sought for evidence of uræmic convulsions, I have never been able to discover any. If, then, such complete retention of the urinary constituents as must of necessity exist in these cases fails *per se* to produce convulsions, it seems tolerably certain that some other factor is necessary for their production.

Dr. Hick's second alternative explanation of the nearly simultaneous appearance of convulsions and albumen may possibly be correct, but if it will negative the statement of Playfair to the effect that "retention of urinary elements could not have been the cause of the attack," for, as will be shown, there may be retention of urinary elements and no albuminuria. As I have already stated, Lusk says it is not the albuminuria but the renal insufficiency that is the cause of the attacks. We have heard from Dr. Andrew Clark of the baneful effects of renal incompetency without albuminuria. Israel, of Berlin, stated recently that uræmia might arise without albuminuria and without nephritis, in consequence of the kidney not being able to do the increased work thrown upon it by the pregnancy. He experimented on rabbits and learned that by gradually accustoming them to the injection of urinary constituents they could bear the introduction of a large quantity without injurious consequences, but that if he injected similar large quantities into animals not previously prepared death rapidly resulted. He does not say, however, that death was preceded by convulsions. These experiments prove only that large quantities of urinary constituents suddenly thrown into an unprepared animal cause death and not, as he would claim, that they produce convulsions.

Now after all that has been said I am prepared to admit that, in the great majority of cases of puerperal eclampsia, urinary constituents in the blood play the part of contributories to the eclampsia, but I cannot accept the theory that they are the sole cause, and in this I follow Playfair as against most writers.

It is now necessary to inquire how the albumen gets into the blood, and what is the condition of the kidney in the albuminuria of pregnancy. Is there a real parenchymatous nephritis, as those who believe with Braun and Bartels affirm there is? Most probably not.

Dr. Angus McDonald published a remarkable paper on this subject, in

which he described the kidneys in a fatal case. To his surprise, no parenchymatous nephritis was present, as he had expected it to be. He says: "The kidneys were quite different from anything I have ever seen in acute renal disease. The sole change was apparently degeneration of the tubular epithelium." In Germany the condition of the kidney under these circumstances has also been noticed to be different from the form met with in acute Bright's disease. The condition is so marked that it has been designated by Leyden "the kidney of pregnancy" (*Schwangerschaftsniere*). Halbertsma, of Utrecht, denies that the condition is one of nephritis. Dr. Hiller a German staff-surgeon, reports the autopsy of a fatal case, and says that there was no sign of any change in the interstitial structure of the kidney. Dr. Flaischlen, of Berlin, gives the differential diagnosis between acute morbus Brightii and the kidney of pregnancy, although he acknowledges that it is not always easy to establish this with certainty. In the latter (kidney of pregnancy), according to him, hæmaturia is not present, the pulse is not so hard and incompressible as in acute nephritis, whilst the presence of fat corpuscles in the urine is a characteristic of the affection. The pathological change is a degeneration of the epithelium of the glomeruli.

Thus we have a series of original investigators who now deny that the condition of the kidney met with in the albuminuria of pregnancy and labor is ever acute Bright's disease, and assert that it is one of simple degeneration of renal epithelium. These investigators, as I have shown, are M'Donald, Leyden, Hiller, Halbertsma, and Flaischlen.

Massage with Successful Results in Phlegmasia Alba Dolens. (By Kochman, Strasburg).—Frau Shaw, convalescent from puerperal fever, again became suddenly sick on the evening of the 30th January, 1883, with the appearances of fever and pain in the left leg, which increased toward morning. K. found upon examination, February 1st, temperature 101.3° F., pulse 96, the left leg very edematous throughout its entire length and very painful, under Poupart's ligament in the fossa navicularis a hard tumor, the size of a pigeon-egg.

The diagnosis was phlegmasia alba dolens as a result of thrombosis of the crural vein. Departing from the usual mode of treatment, with the exception of a laxative favorable in all such cases, the author employed massage with remarkable results. First, the left leg was laid upon an inclined plane, with the feet higher than the head. Then K. kneaded the limb, beginning with the foot, at first with gentle pressure, later somewhat more energetic, always paying special attention, however, to the inner muscles of the thigh, to the adductors, which had become as large as painful, and by their increased weight pulled upon the tumor. Upon them massage was made from below and within upward and outward, and afterward the whole were raised so high by means of a sand-bag

placed beneath that that they were somewhat higher than the femur and the tumor formed by the thrombosis of the vena cruralis. In consequence of the relaxation of the swollen adductor and skin thus produced, circulation was better and the pain which had been very great ceased.

Surprised at the result of the first trial, Kochman kneaded the limb a second time the same day, followed the massage, however, by a Priessnitz bandage; he raised the foot upward with care, bandaging it with bandage a hand-breadth in width, then covered it as closely as possible with silk, and ended with a padded bandage. The next morning found bandage and bed dripping wet, the swelling had gone down to a remarkable extent in the leg, only the adductors presented edema, and they only to a slight extent. While the patient remained quiet there was no pain and temperature was normal. The tumor had decreased to a marked degree, and the author now ventured to gently knead it as he had not done before, lest emboli should be formed. In the evening the same treatment was repeated, and a cup of inf. herb. jaborandi was given to promote perspiration.

On the fourth day after the beginning of the treatment the patient was out of danger; no pain, and the tumor only one-third its original size. To-day, after twelve days, the tumor has entirely disappeared; the patient has gotten up and walked about with the aid of a cane. General condition good, color has become fresher, and strength increasing.

While the author recommends this method, it must not be forgotten that massage of the thrombotic spot demands extreme care and should only be made after the third sitting, and then very gently, so as not to give cause for the formation of an embolus by breaking the point of the thrombosis projecting into the vessel.—*American Practitioner*

Hot-Water Enemata in Delivery.—The value of hot-water enemata as a means of hastening delivery, apart from its use in the removal of fæcal accumulation, in such cases of tedious labor in which either ergot or the forceps are admissible, has been hitherto unaccountably ignored in practice, as far as my experience extends. I formerly had warm-water enemata given with the usual object of removing fæcal obstruction from the rectum; in most cases, an increased rate of dilatation of the os followed. Latterly, I have had enemata of hot, not merely warm, water administered, whether there were any appreciable collections of fæces or not, and always with the result of an accelerated rate in the progress of labor. The fact of the os dilating under the influence of the enema, whether there was an appreciable quantity of fæces or not in the rectum, proves that their presence does not prevent dilatation by causing spasm; at least, not in the majority of cases. It follows that the hot enema must act as a direct and powerful stimulant, to the uterine muscle, and I feel convinced, I may add, as a result of close observation, also to the vol-

untary muscles engaged in the act of parturition. Judging from the sense of relief which follows its administration, it has, at the same time, a relaxing and soothing effect on these same parts; analogous, in short, to the effect of hot water applied in the familiar form of a fomentation to an inflamed and painful swelling.

I believe I am justified in adding that there is less atony of the uterus after delivery, when a hot enema has been given, and consequently less tendency to *post partum* hemorrhage. On this account, it has not the after-relapsing effect of chloroform on the uterus it otherwise commonly has.

I submit that it would be as well to give so simple a means of treatment as hot-water enemata a trial, in cases in which either ergot or the forceps would be used, as it possesses obvious advantages over both.— D. L. Beckingsale, M.D., in *British Medical Journal.*

Antiseptics in the Puerpera.—We have for some time past given our preference almost exclusively to LISTERINE as an antiseptic in the puerpera. We think it has *real* advantages over any other, while it certainly is much more acceptable to the patient. The objects to be attained in the use of vaginal washes after confinement are, first, to secure cleanliness, second, to arrest and prevent putrefaction, and last, but by no means least, to promote *early*, healthy action in the lacerated soft part—channels through which septic matter may be absorbed. The importance of this early reparative action cannot be overestimated, as it is a well-known fact that with the healing process once begun, septic virus is repelled, in lieu of being absorbed, as is the case before healing begins or when the abraded surfaces have taken on unhealthy action. We had long employed the carbolic acid for the purposes above enumerated, but observing disagreeable constitutional influences from its use, we selected the LISTERINE, which has proven a powerful non-toxic antiseptic, promptly promoting the reparative process, and substituting an agreeable perfume for a noxious odor.— *Prof. F. L. Sim, M.D., Memphis College Hospital, in Mississippi Valley Monthly.*

Nitrous Oxide as an Anæsthetic in Labor.— Dr. Tittel gives a report (*Wiener Med. Blätter*), of over fifty trials which he has made of the inhalation of nitrous oxide gas in parturition. He employed it chiefly in primiparæ with very severe pains, and found a diminution of the suffering in every case. He found it acted better when given in the first stage, as its effects lasted into the second, and quiet inhalation was more difficult when it was attempted to be given in the second stage. The pulse was generally retarded, and the fœtal pulsations, on the contrary, generally accelerated. The pains were in many cases increased in strength and frequency, and Dr. Tittel found this action of the gas very serviceable

in multiparæ with few and weak pains. Vomiting was arrested in four cases by the inhalation of the gas, and the only results which were observed were two cases of convulsions, one hysterical and the other true epileptic.—*Medical Record.*

Asafœtida in the Treatment of Abortion.—In the *Journal de Médecine de Paris* are collected the results obtained by several observers in the prevention of abortion and premature labor by asafœtida. Dr. Laferla, acting upon the theory that the death of the fœtus was owing to an asthenic condition of the uterus, administered the drug in a number of instances. In nearly ninety per cent. of the cases so treated the patients (who had aborted from two to five times in former pregnancies) went on to full term. Drs. Giordano and Carzani announce equally favorable results, though the number of their cases was smaller. The latter prescribes the drug in pill form in doses of one and a half grain twice a day, gradually increased to twelve grains per diem. Dr. Gourgnes recommends the administration of asafœtida, emulsion with the yolk of an egg, by the rectum.—*Medical Record.—American Medical Digest.*

Abdominal Inunction During Pregnancy.—Dr. Burke, in the *New England Med. Monthly*, says: "In the last three or four months of pregnancy all women suffer discomfort from the distention of the abdominal walls, which I have found greatly relieved by the free use, at least once a day, of some unctuous material, as vaseline or sweet lard, and in many cases the formation of the lineæ albicantes is prevented."—*Medical Record.*

II.—GYNECIC.

Etiology of Endometritis Fungosa, especially the Chronic Hyperplastic Endometritis of Olshausen.— Dr. Breunecke, (*Archiv für Gynäkologie*), states that his intention is not so much to add to the pathological and histological knowledge of this affection as to throw some light upon the origin of this form of uterine disease. For a long time all forms of fungous growths associated with metrorrhagia, and sometimes with purulent discharge, were grouped together under the one name, endometritis fungosa. Later Olshausen separated the various forms somewhat, and Bischoff divided them into four anatomically different affections: (1) that form consisting of œdematous normal tissue, and granulation tissue rich in vessels; (2) the decidual form; (3) the diffuse adenoma; and (4) the diffuse sarcoma. Bischoff's third and fourth forms are evidently nothing but the chronic hyperplastic endometritis of Olshausen, divided into these two categories only because in the one case the uterine glands prevail, in the other the intercellular substance, but clinically the same. So Ruge distinguishes a glandular and an inter-

stitial form, and a mixed form between the two. The author accepts the distinction, but claims that it does not depend upon any essential difference in the disease itself, but upon the age of the patient. The older the patient, the more does the glandular form prevail, while with younger persons the intercellular form is most marked. To illustrate this view, and as a groundwork for conclusions as to the ætiology, Breunecke gives the history of six cases. The first and third cases, occurring in women fifty and fifty-one years old, were markedly of the glandular form; the second and fifth, aged thirty-one and forty-three, of the interstitial type. The mixed form occurred in cases four and six, in patients forty-eight and twenty-six years old.

As regards the ætiology, the author first notices as common to all the cases that before the profuse hæmorrhages characteristic of the disease, there were irregularities in the menstruation. From this fact Beunecke draws the conclusions that the first factor in the case is functional disturbance on the part of the ovaries, characterized by a retardation of ovulation. As a result of such retarded or difficult ovulation, we have congestion of the uterine mucous membrane, not sufficient, however, to cause rupture of the blood-vessels. Such congestion, unrelieved by hæmorrhage, leads to hyperplasia of all the elements constituting the uterine mucous membrane. When the repeated congestion finally lead to rupture of the blood-vessels, we have a mucous membrane which would favor profuse and long continued hæmorrhage.

This condition of impaired function of the ovary occurs naturally at the climacterium; hence most of these patients are at or past the menopause. It is known that Graafian follicles may ripen after the cessation of menstruation, and it is fair to suppose that the gradual thickening of the albuginea preventing the most of such ripening follicles from bursting the resulting congestion may be only now and then relieved in the way described. A similar effect is produced in younger persons by any weakening influence affecting the general health, or the sexual organs in particular.

As regards prognosis and treatment, the following may be said: The curette must be the chief method of treatment. After this, the restoring the lost energy to ovulation, general tonic treatment must be adopted, and in proportion as this is successful will relapses be infrequent. This applies to those cases where the anomalies of menstruation are due to general debility. When, however, physiological or pathological changes of structure in the ovaries are present, the prognosis must be more guarded. In these cases, either all stimulus on the part of the ovary must be prevented or the results of this stimulus, the hypæmia of the mucous membrane, be neutralized. For this latter purpose the constant use of glycerine tampons is of great service. The author condemns the use of caustics, as it is his opinion that neither is this change in the

mucous membrane of a malignant character nor does it tend to become malignant. In accordance with this theory, if a case should threaten to terminate fatally, he would remove the overies rather than the uterus.

The author finally says that he by no means considers every case of fungoid growths accompanied by metrorrhagia as of ovarian origin. They may occur as a result of various local uterine troubles, as chronic catarrh, marked retroflexion, stenosis of the os internum, and small fibroids. As characteristic of the ovarian form are the irregular menopauses which precede the hæmorrhages, the tendency to recurrence, and the greater quantity of fungoid masses brought away by the curette.

The type of fungoid degeneration connected with abortion, the author thinks, is characterized by remains of the decidua vera, and the observation of Lüstner and Ruge confirm this view. At the end of the article is a table which shows the anomalies of menstruation before and in consequence of the three following forms of endometritis: (1) endometritis hyperplastica ovarialis; (2) endometritis fungosa or hyperplastica uterina; and (3) endometritis decidualis.—*Boston Med. and Surg. Journal.*

Cannabis Indica; *A Valuable Remedy in Menorrhagia.*—Mr. J. Brown, of Bacup, observes:

"Indian hemp has been vaunted as an anodyne and hypnotic, having the good qualities of opium without its evils. Also in dysmenorrhœa and insomnia it has not proved of much benefit. The drug has almost invariably produced some marked physiological effect even in small doses. Text-books give the dose as ten minims and upwards, but five minims is the largest dose that should be given at first. If bought from a good house, the drug is not inert or unreliable. A drug having such marked physiological action ought to have a specific use as a therapeutic agent. Indian hemp has such specific use in menorrhagia — there is no medicine which has given such good results; for this reason, it ought to take the first place as a remedy in menorrhagia, then bromide of potassium and other drugs. The *modus operandi* I cannot explain, unless it be that it diverts a larger proportion of blood to the brain, and lessens the muscular force of the heart. A few doses are sufficient; the following is the prescription: ℞ tincturæ cannabis indicæ *m* xxx; pulveris tragac. co. ʒj; spiritus chlorof. ʒj; aquam ad ʒij. One ounce every three hours. Four years ago I was called to see Mrs. W,, aged 40, multipara. She had suffered from menorrhagia for several months. Her medical attendant had tried the ordinary remedies without success. Indian hemp was given as above. Its action was speedy and certain. Only one bottle was taken. She was afterwards treated for anæmia, due to loss of blood. Twelve months after this my patient sent for a bottle of the "green medi-

cine." I learnt afterwards that she had sent this medicine to a lady friend, who had been unsuccessfully treated by another medical man for several months for the same complaint. It proved equally successful. The failures are so few, that I venture to call it a specific in menorrhagia. The drug deserves a trial. It may occasionally fail; this, however, is not to be wondered at in a complaint due to so many different causes, and associated with anæmia and other cases of plethora."

Robert Batho, M.D., M.R.C.P., Castletown, Isle of Man, writes in reference to the same subject: "Considerable experience of its employment in menorrhagia, more especially in India, has convinced me that it is, in that country at all events, one of the most reliable means at our disposal. I feel inclined to go further, and state that it is *par excellence* the remedy for that condition, which, unfortunately, is very frequent in India.

I have ordered it, not once, but repeatedly, in such cases, and always with satisfactory results. The form used has been the tincture, and the dose ten to twenty minims, repeated once or twice in the twenty-four hours. It is so certain in its power of controlling menorrhagia, that it is a valuable aid to diagnosis in cases where it is uncertain whether an early abortion may or may not have occurred. Over the hemorrhage attending the latter condition, it appears to exercise but little force. I can recall one case in my practice in India, where my patient had lost profusely at each period for years, until the tincture was ordered; subsequently, by commencing its use, as a matter of routine, at the commencement of each flow, the amount was reduced to the ordinary limits with corresponding benefit to the general health. Neither in this, nor in any other instance in which I prescribed the drug, were any disagreeable physiological effects observed.

I could say a few words in its favor, as to its action in allaying irritative cough, but I prefer confining myself to a point on which experience has left no room for doubt."—*British Medical Journal.*

Massage of the Uterus.—The scientific manipulations comprised under the term uterine massage may be divided into four groups: 1. Those intended to benefit lesions of which the seat is easily accessible from the exterior; 2. Those which are applied to all the lower abdominal region, and which often constitute a preliminary operation; 3. Massage of the uterus through the abdominal wall; and, 4. Bimanual massage through the vagina and abdominal wall combined. The cases of the first group are generally in superficial subperitoneal exudations, or else situated in the abdominal walls above Poupart's ligaments. Often it is necessary to apply massage to the hypogastric region; the bladder is emptied, and the patient placed on her back on a resistant surface. The operator

catches up and presses between the palm and the fingers the skin and superficial tissues. The whole abdominal wall, as far up as the umbilicus, is submitted to this treatment. Then the deeper tissues are subjected to it. These pinchings should be alternated by frictions with the fingers and palms of the hand, the whole operation lasting five or ten minutes. The skin should be previously oiled, and great delicacy be used in the manipulations. In many cases the pains appear to be situated in the abdominal wall, and the masses gradually abolishes the sensibility. After this, one may, if necessary, apply massage through the vagina and abdominal wall simultaneously. When an hypertrophied uterus, for example, can be grasped between the fingers, the hands may be applied flat on the abdomen, the fingers directed toward the pubis; then, by short and steady pressure, the masseuse seeks to grasp the uterus and knead it. More often it will be necessary to apply massage through the vagina. The index and middle finger of one hand are introduced into the vagina, and their extremities, carried into the posterior cul-de-sac, push the neck forward several times, so as to give mobility to the whole uterus. The other hand is placed on the abdomen, and grasps the uterus, the fingers in the vagina serving as a fixed point. When the organ is grasped, it is steadily compressed between the fingers of the two hands for several seconds. This is alternated by lifting up the uterus. Then, the two fingers being placed in the anterior cul-de-sac, the movements already described are repeated. The uterus should be grasped, as far as possible, between the fingers, and subjected to intermittent pressure or kneading. Jackson has recommended that the fingers be also introduced into the rectum. Displacements of the uterus, flexions, and versions have been frequently treated by massage, but without signal success. Better results are obtained in chronic metritis, and especially in cases of old pelvic peritonitis. Massage is positively contra-indicated in any acute accidents or a tendency toward acute manifestations.—*Journal de Méd. de Paris.—Medical News.*

Carcinoma of Both Ovaries. Double Ovariotomy. Resection of Intestine and Bladder. Recovery.—Dr. Moritz Schustler (*Wein. Med. Woch.*, No. 2, 1883) reports the following interesting case from Billroth's clinic:

A married woman who had had six children and one miscarriage had suffered from the following symptoms for four years: intense pain in the hypogastrium at intervals, gradually growing worse, accompanied by fever and tenderness; later shortness of breath and palpitation of the heart, frequent micturition and constipation. A tumor was first noticed five months before the operation, in the left side, the size of an apple, which grew rapidly, so that at the time of the operation it reached almost to the false ribs. Loosely connected with it was a second tumor to the right, and not so large as the first. There was only slight mobility,

the surfaces were nodulated, there was no fluctuation. The uterus seemed pushed to the left side and behind. The operation was done without spray, but under strict antiseptic precautions. On reaching the tumor, and attempting to lift it out of the abdomen, it was found to be closely adherent to the upper part of the posterior wall of the bladder. As the tumor seemed to be malignant Professor Billroth decided to excise the adherent portion of the bladder, and a piece three centimetres long and two centimetres broad was removed. The wound was closed by six fine silk sutures. It was then found that the posterior surface of the tumor was so firmly adherent to a part of the small intestine that it could not be dissected off. A piece twelve centimetres long was therefore cut off, and the two ends of the severed intestine joined by fourteen sutures, five internal at the insertion of the mesentery, and nine for the rest of the circumference. The rest of the operation presented no especial difficulties. The convalescence was undisturbed by any complication. Flatus passed on the second day, and on the sixteenth there was an operation of the bowels following an enema. The catheter was used for the first few days only. On the twenty-fourth day the patient left the clinic well. According to later accounts the woman is in perfect health, and fifteen months after the operation there has been no sign of a recurrence. This is said to be the second case of resection of the intestine on record, the first having been performed by Madelung, and described in the *Berliner klinische Wochenschrift*, No. 6, 1881.—*Boston Medical and Surgical Jour.*

The Treatment of Chlorosis by Blood-Letting.—Well may one despair of arriving at a definite, orthodox, and certain treatment of disease. To read such a title as this makes one rub one's eyes, and, with that disappointed feeling we know so well on awaking from a dream of pleasant unrealities, exclaim, "then it is not true that quinine cures ague, that mercury and iodide of potassium are the proper treatment for syphilis; that chlorosis is amenable to an iron treatment." Man is proverbially ill-tempered when just aroused; therefore Dr. Dyes, who has forwarded to us a paper on this subject and with this heading, must excuse us if, under the circumstances, we venture to ask him to give us his credentials ere we can allow him to teach us such an astounding doctrine. If there is one fact certain in medicine, it is this, that iron given in sufficient doses will rapidly ameliorate many cases of chlorosis. Naturally enough, a disease such as this, which is a resultant of many conditions, will require a careful adaptation of means to the particular case on hand, but that a large number are rapidly relieved by iron, none with adequate experience can dispute. It is one of the unfortunate results of the competition of the present day, of the inevitable pitting of man against man, that everyone of us is trying to say something that no one else has said before him. Success in the struggle is not easy; the dishes served up by

us are mostly *entrées*, old friends in new and unsubstantial dresses, but we are compelled to admit that Dr. Dyes has accomplished it in saying that the blood of the chlorotic is thick and dark colored, and that bleeding will remove these abnormalities. It has been said before, and the statement applies here, that what is new is not true. That what is true is not new is often made part of the proverb, but this does not apply so well, for if facts depend upon the teachings of experience, there are none. Dr. Dyes does not think that simple loss of blood can ever produce anemia, because he has never seen it do so. He should have waited to write upon the subject until a riper experience had come to him.—*British Medical Journal.*

III.—DISEASES OF CHILDREN.

The Treatment of Croupus Pneumonia.—In a dissertation on the treatment of croupous pneumonia (*Wiener Med. Blätter*, Feb. 22 and March 11) Dr. Jürgensen speaks first of the treatment of the high temperature. He considers cold baths to be a necessity when the temperature exceeds 41° C. (105·8° F.), unless the heart should be very weak, when they may induce collapse. Even if the temperature be under 40° C. (104° F.) they should be employed, if cerebral or cardiac symptoms be present. Baths, or some other antipyretic treatment, may be advantageously employed as a prophylactic in light cases. He suggests that cold applied to the body may limit the development of the micro-organisms, but he acknowledges that the course of pneumonia is not always checked by the most energetic withdrawal of warmth. The cold pack is recommended as an adjunct to baths in severe cases of pneumonia, and as a substitute for them in lighter cases.

Antipyretic drugs may be supposed to act directly on the micro-organisms or on their seat, rendering their future development impossible. No specific for pneumonia has yet been found. Iodine, recommended by Schwarz, has not been tried in a sufficient number of cases to prove its efficiency. Salicylic acid is not suitable for use in pneumonia, as it lowers the temperature too quickly and too much. Quinine, on the other hand, is very suitable; it lowers the temperature sufficiently and permanently, and may be employed in large doses, as the short duration of the illness prevents any fear of derangement of the digestion. It should not, however, be employed for a great length of time to the exclusion of baths.

Wine is demanded in pneumonia, and children may take from half a litre to a litre of light red Bordeaux, adults double that amount. Fever patients can take with impunity an amount which would intoxicate a healthy individual. The wine contributes a certain amount of fluid, which is much needed by the tissues; the alcohol, while not increasing

the bodily warmth, contributes an elasticity without the necessity on the part of the body to assimilate food. The objection that the use of wine from the first will so accustom the patient to it that it will not be useful as a stimulant, is met by the statement that such an administration provides against exhaustion and so obviates the necessity for stimulants, which, if they should be wanted, may be found in the strong wines, champagne, and brandy, or in the subcutaneous injection of camphor or ether. There is no difficulty in discontinuing the wine when it is no longer needed, but weakness of the heart may necessitate its continuance, or even increase, for a few days after defervescence.

Sufficient nourishment is very necessary, and Dr. Jürgensen has found that fever patients treated by baths can take plenty of nitrogenous food. Milk is most useful at first, and may be given up to several litres a day, one or two ounces of cognac being mixed with each litre. Raw meat minced, with bread and butter, and even more complicated dishes, are not to be forbidden. This treatment is adopted with the aim of keeping the patient alive by rendering the heart capable of performing its work.

The danger to collapse after the use of baths is not to be feared even in weak children, as the alternative is to abandon the child to the action of the disease if the fever continue in spite of the use of quinine. Baths may even be beneficial in weakness of the heart; for, when a relaxed state of the vessels, and of the muscles generally, widens the bed of the blood-streams, the stimulation of the bath narrows the peripheral arteries, giving greater resistance, and so enables more blood to flow along other channels. When cold baths have caused collapse, it has been from insufficient watchfulness on the part of the medical attendant, especially as regards the time of crisis, when the temperature falls of itself, and when baths in addition would do harm. The increase in the temperature of the body stimulates the heart, and when, by cold baths, this stimulant is away, another must be substituted for it. The crisis may come quite unexpectedly and without warning; and when quinine is employed as an antipyretic this crisis may occur during its time of action, which is from six to seven hours. In such a case baths are much safer, as their action lasts for a much shorter time. It is a good rule to employ a cardiac stimulant regularly on the day of crisis.

Digitalis can be employed in pneumonia only as a regulator of the heart's action. It is supposed to act by prolonging the diastole, and so increasing the period of rest of the heart, and enabling it to be better nourished. But in pneumonia the rapidity of the pulse is often in direct relation to the increased respiration, and to interfere with one without affecting the other is to disturb the equilibrium between them. Only in cases of irregular and intermittant pulse is digitalin sometimes of service.

Inhalations of turpentine are useful in treatment intended for the lungs, especially in cases of fœtid expectoration.—*London Medical Record.*

Invisible Cutaneous Perspiration in Healthy and Febrile Children.—Dr. Eckert, in the *Vratch*, publishes the results of her observations on thirty healthy children from two to fourteen years of age, and on twenty-seven suffering from various febrile diseases. The age of the febrile children varied from eighteen months to thirteen years. The conclusions at which the author had arrived are summed up thus: *a. For healthy children.*—1, invisible loss of water by the skin in children proceeds with greater energy than in adults; 2, the loss is greatest in children of younger age (under five years), and gradually becomes less as age, height, and weight advance; all conditions being equal, any rise of barometric pressure increases loss of water by the cutaneous surface, while any increase of the humidity of the surrounding air inhibits invisible perspiration. *b. For febrile children.*—1, in the febrile state invisible perspiration is augmented; 2, in enteric fever, the greatest loss of water by the skin coincides with the period of maximal mean daily temperature, afterward invisible perspiration decreases with the fall of febrile temperature, and in the period of convalescence it descends considerably below the normal level; 3, similarly, in the course of relapsing fever, there is observed more or less considerable increase in invisible perspiration during the attacks; having reached its maximum at the time of crisis the amount of evaporation rapidly falls, though during the first twenty-four or thirty-six hours after the crisis it remains still rather increased above the standard. During the apyretic intervals and after the termination of the disease cutaneous loss of water falls below the usual level; 4, in scarlatina invisible perspiration is considerably increased.—*Medical Record.*

Perchloride of Iron in Diphtheria.—Dr. Andresse of Teltow (*Deutsche Med. Wochenschrift*), recommends perchloride of iron in diphtheria, a gargle of five or six drops of the liquor to a small cupful of warm water to be used several times a day by sick and healthy alike, and the affected throat to be thoroughly brushed with the liquor, diluted with two or three times its amount in water. The throat should also be sprayed with the same dilution as is used for gargling. Internally, he prescribes a solution of quinine (one part in 120) of which a teaspoonful should be taken every hour undiluted in order to obtain the beneficial effect of its local action.—*London Medical Record.*

Laparotomy in the New-Born.—At a recent meeting of a medical society in Vienna (*Wiener Med. Blätter*), Dr. Felsenreich showed a child, two weeks old, on whom he had performed a radical operation for the cure of umbilical hernia. The birth had been easy and natural, and the child itself was strong and healthy, with no other malformations. A tumor of the size of a lemon was situated in the abdominal wall, the umbilical cord being attached to its summit. The separation between the recti muscles

was eight centimetres long and four centimeters broad, and contained intestines and the margin of the liver. Twelve hours after birth the operation was made in the usual way, the hernial sac being attached to the edge of the skin-wound, which was closed by twelve silk sutures, and dressed with iodoform. The operation was completed in twenty minutes, without much sign of pain on the part of the child, which took the breast immediately afterward, and had a normal stool on the second day. The progress of the case was very satisfactory throughout, although the healing of the skin was somewhat slow.—*Medical Press.*

Bibliography.

The International Encyclopedia of Surgery. A Systematic Treatise on the Theory and Practice of Surgery by Authors of Various Nations. Edited by John Ashhurst, Jr., M.D., Prof. of Clinical Surgery in the University of Pennsylvania. Illustrated with Chromo-lithographs and Wood-cuts; in Six Volumes. Vol. III. New York: Wm. Wood & Co.

The third volume of this great surgical work has been somewhat tardy in making its appearance, but the good character of the book in general and its excellence in certain particulars show that the profession have been well repaid for waiting. The volume opens with an article on the injuries and diseases of the muscles, tendons, and fasciæ, by P. S. Conner, M.D., of Cincinnati.

Considering the importance of this subject in comparison to some of those which follow, the article might as well have been made to take a back seat; for to judge this book by the opening pages, as is commonly done, would be very wrong indeed. Whatever may be said of the subjects of minor importance treated of in this volume it cannot be denied that everything has been done to swell the reading matter to the proportions demanded by an encyclopedia even at the risk of encroaching upon fields not purely surgical. Five hundred pages or two-thirds of the book are devoted to the surgery of the blood-vessels, making an exceedingly important contribution to this branch of surgery, and one which cannot fail to give the work a wide circulation. The overlapping of subjects mentioned in the preface conveys no idea of superfluity, and must be considered necessary to the completeness of the articles. The valuable aid in the way of illustrations recruited from the medical and surgical history of the rebellion, and the works of Professors Esmarch, Sédillot, etc., together with the vast array of statistics collected from every quarter, make the work probably the most important book of refer-

ence on certain subjects in the English language. Thus a more elaborate treatise on the surgery of the blood-vessels could hardly be wished for, and yet the importance of the subject must have suffered had any less space been taken.

The article on injuries and surgical diseases of the lymphatics by Edward Bellamy, F.R.C.S., comes second in order, and discusses wounds of the lymphatics and lymphatic glands, wounds of thoracic duct and other large trunks, lymphangeitis of the reticular, tubular, septic and uterine varieties, adenitis, varicose lymphatics, elephantiasis arabum, lymphadenosis, syphilis and cancer of the lymphatics. In the terms used to designate some of the diseased conditions of the lymphatics, there is, as may be expected, some confusion, but the list of hard names is well handled and the least objectionable ones made use of. Elephantiasis arabum is said on the authority of Manson, Lewis, and Bancroft to be caused by the presence in the lymphatics of the filaria sanguinis hominis. Lymphadenosis is diagnosticated from leucocythemia by a reduction in the number of red corpuscles in the former, while the number of white cells remains the same—from struma by the lack of a tendency to periadenitis, suppuration, or degeneration; by the large size and quick growth of the tumors, and the general glandular invasion—from cancer by being a primary glandular affection, early development, mobility of superimposed integument, presence of splenic or thyroid mischief, and lymphoid in microscopical character instead of epithelial. In malignant lymphoma extirpation of gland holds out no chance of success as is sometimes the case with sarcoma. The prognosis of lymphadenosis is exceedingly unfavorable, and the surgical treatment (and in fact medical also) usually hopeless.

It would be impossible in a short notice of this kind to even mention the many points of interest discussed, and a few stray things picked up here and there must suffice. On the subject of hemorrhagic diathesis Dr. John A. Lidell attributes this peculiar condition to an abnormally large size and superficial arrangement of the veins and arteries, together with an unduly large supply of blood. It is said to be the most hereditary of all hereditary diseases, and is handed down from one generation to another by both direct and indirect transmission. The most important method of hereditary transmission is that which occurs in non-bleeder members of bleeder families, for their extraordinary fruitfulness tends greatly to multiply this unfortunate class. Of 650 authentic cases of hemophilia, 602 occurred in males and 48 in females—thus the fully developed condition is vastly more frequent in males, while partly developed hemophilia is by no means uncommon among the opposite sex. The Anglo-germanic and Jewish races are said to be most prone to the disease. The prognosis is unfavorable. According to Grandidier about half of the cases die before the eighth year. While, perhaps, most of

these cases die young, some bleed to death later in life, and others survive the malady or outlive its pernicious tendency.

The article on aneurism by Richard Barwell, F.R.C.S., deserves special praise. Though the prevailing ideas, of the past have placed aneurism in the domain of surgery it is far from being a pure surgical subject, and in these pages may be found a number of facts pointing to the future abandonment of the ligature in many cases for the more rational and less hazardous control of the circulatory organs by medicinal agents and hygienic measures. Such a change in the professional mind can in no respect be regretted, for it is not difficult to see how surgical interference may do much harm in that class of cases commonly looked upon as hopeless. That a patient is suffering from a dangerous form of aneurism and is not expected to recover is no reason why he should be made the subject of a questionable experiment in surgery, while rest, diet, etc., hold out a possible chance. On this point the statistics found in the article are decidedly suggestive.

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The Practitioner's Ready Reference Book. By Richard J. Dunglison.

The fact that this book has already passed through two editions is the best testimony of its value to a certain class of busy practitioners. It can certainly lay claim to giving all that it professes to do. It begins with the Hippocratic oath and concludes with the rules for making post-mortem examinations. Naturally, enough, the interval between these two adjuncts of medical science is capable of being filled with the most varied and diverse subjects. Thus we find rules for the guidance of the practitioner in his own practice and in his dealings with his professional brother, tables of doses of remedies in general, of hypodermic injections, a list of incompatibles, of the modern treatment of diseases, a number of selected prescriptions, a diagnostic table of fevers, a table of poisons and their antidotes, the method of urinalysis, how to use a galvanic battery, a clinical thermometer, etc., etc. The most important subjects are briefly referred to, and the least important are not forgotten, so that we also find directions for removing ink stains, and other similar practical information. To those, whose libraries are limited and who can not find access to larger collections of medical literature, this book will certainly prove acceptable. The alphabetical arrangement of all the tables makes them doubly valuable for reference. Certain errors have crept into the work, as for instance, in the directions for preparing nutritive enemata, where no allusion is made to the addition of any digestive ferment, and most of the formulæ, except the digested meat enema, would give mixtures, practically valueless for all nutritive purposes; such inaccuracies are few and are more than compensated for by the really valuable information contained in other parts of the book. A point of special interest is the table of celebrated prescriptions or remedies, under which head are

embraced many of those prescriptions which have become historical and which are commonly designated by the name of the inventor, such as Abernethy's pills, Churchill's tincture, Javelle's solution, etc. These formulæ are very seldom mentioned in this way in the various treatises upon materia medica, and yet are frequently referred to in the older and more modern literature by the proper name first given to them. Other parts of the work show similar care in the preparation. J.E.

The St. Louis Medical Society.—On June 23d, 1883, Dr. Atwood introduced the following which was adopted by the St. Louis Medical Society, after considerable discussion:

WHEREAS, At the recent session of the American Medical Association, a preamble and resolution were offered for the consideration of said Association, purporting to represent the sense of the St. Louis Medical Society upon the propriety of preparing a new code of ethics, or altering and changing the existing code in accordance with the present relations of the profession, and

WHEREAS, In said preamble the assertion is made that, "the Code has accomplished all it was designed it should, but at present many of its features are obsolete and not adapted to our wants. The necessity of an early revision is very apparent, is loudly called for in all parts of our land, and cannot be repressed much longer. * * * The time has come when the loud and soon universal call will have to be heeded;" and

WHEREAS, The St. Louis Medical Society did not instruct, "That the Committee be authorized to prepare a code of ethics which in their view will meet the wishes of the profession, and submit the same to the meeting of 1884;" therefore,

Resolved, That the St. Louis Medical Society distinctly repudiates the the statements contained in said preamble and again expresses its fealty to the existing code of ethics as a time honored and most fundamental law of the profession, and specially deprecates any action calculated to reflect upon its loyalty to those principles which have heretofore secured immunity from the machinations of schismatics within or enemies without. A. H. OHMANN-DUMESNIL, M.D., Rec. Sec.

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